# Case Mix Reviews Update ...and Much More!

# Agenda

# Case Mix Reviews Update .....and Much More!

9:00 to 9:30	Registration
9:30 to 10:00	State Review Statistics and Case Mix MDS Items Most Frequently Unsupported
10:00 to 10:30	"Revised" Supportive Documentation Guidelines
10:30 to 10:45	BREAK
10:45 to 12:00	NEW Spiral Training Manual and Much More
12:00 to 1:00	LUNCH
1:00 to 2:00	CMI Report and Much More
2:00 to 3:00	ADLs and Much More
3:00 to 3:30	Case Mix Reviews and Much More

# **Louisiana Nursing Home Association And**

#### Louisiana Department of Health and Hospitals Case Mix Reviews Update.....and *Much More!* May 2005 Evaluation

Instructions for completion: Please check or circle the response that most appropriately indicates your evaluation of the seminar and presentation.

appropriately indicates you	ır evalualic	on or the	Semina	ar and	presen	tation.
Name (optional)						
Facility (optional)						
Did this training provide inf Completely	ormation o		eas tha		elp you Not	
The level and complexity c Too Advanced		•			Too	Basic
4 = Excellent	3 = God	od	2	= Fair		1 = Poor
Overall rating of the proc	gram:	4	3	2	1	
Presenter		4	3	2	1	
Objectives Met		4	3	2	1	
Content Appropriate		4	3	2	1	
Physical Environment App	ropriate	4	3	2	1	
Comments and Suggestion	<u>ns:</u>					

Please complete and leave on the registration table. Thank you.

# **State Statistics**

#### **Overall State Statistics Report**

Facility Statistics		
Total Number of Facilities Subject to a Review	142	100%
Total Number/Percent of Facilities Reviewed	53	37%
Total Number/Percent of Facilities with Greater than 40% Unsupported	12	23%
Total Number/Percent of Facilities with 40% or Less Unsupported	41	77%
Assessment Reviewed Statistics		
Total Number/Percent of Assessments Subject to a Review	5,373	100%
Total Number/Percent of Assessments Reviewed	1,526	28%
Total Number/Percent of Assessments Unsupported	471	31%
Total Number/Percent of Assessments Supported	1,055	69%
Unsupported Percent by ADL and or Other		
Total Number/Percent of Unsupported Assessments	471	100%
Total Number/Percent of Unsupported Assessments Based on ADLs only	119	25%*
Total Number/Percent of Unsupported Assessments Based on Non-ADLs	135	29%**
Total Number/Percent of Unsupported Assessments Based on		
ADLs and Non-ADLs	217	46%***

Note: Data as of 3/11/2005

<sup>\*</sup> RUG-III classification changed due to unsupported ADLs only.

<sup>\*\*</sup> RUG-III classification changed due to unsupported Non-ADLs only.

<sup>\*\*\*</sup> RUG-III classification changed due to unsupported ADLs and Non-ADL RUG-III Items.

#### **RUG-III Classification Summary**

#### **Number of Assessments**

		Pre Review		
RUG-III Class	Total	Unsupported	Percentage Unsupported	Post Review
Extensive Services	198	58	29%	167
Rehabilitation	275	69	25%	268
Special Care	274	85	31%	237
Clinically Complex	278	73	26%	285
Impaired Cognition	262	113	43%	219
Behavior Problems	94	31	33%	89
Reduced Physical Functions	145	42	29%	261
Total	1,526	471	31%	1,526

# Most Frequently Unsupported MDS Items

# **RUG-III String Validation Sorted by Percent Unsupported**

Item Location	Item Description	Frequency	Unsupported	Percentage Unsupported
P1b, H3, P3	3 Days, 45 Minutes OT, PT, ST; 2 + Nursing	35	21	60%
B1, N1a,b,c	Coma, Not Awake, Completely	2	1	50%
J1h, I2e	Fever and Pneumonia	4	2	50%
J1h, J1o	Fever and Vomiting	2	1	50%
B2a, B4, C4	Impaired Cognition	380	183	48%
I1a, O3, P8	Diabetes, Injections, Physician Order	32	15	47%
P7, P8	Physician Visits, Order Changes	71	32	45%
M4c, M5	Open Lesions and Skin	31	11	35%
K5b, K6b, I1r	Feeding Tube with High Calories, Fluids and Aphasia	3	1	33%
K5b, K6	Feeding Tube with High Calories and Fluids	10	3	30%
P1b	5 Days, 150 Minutes of OT, PT, ST	257	71	28%
M6b, M6f	Infection of Foot with Dressings	4	1	25%
K5b, K6, I1r	Feeding Tube with High Calories and Aphasia	53	9	17%
M6c, M6f	Open Foot Lesions with Dressings	18	3	17%
M2a, M5	Stage 3 or 4 Ulcer and Skin	73	10	14%
M4g, M5	Surgical Wounds and Skin	63	7	11%
M1, M5	Ulcers and Skin Treatments	62	2	3%
K5b, K6a	Feeding Tube with High Calories	177	1	1%
J1h, J1c	Fever and Dehydration	0	0	0%
J1h, K5b	Fever and Feeding Tube	5	0	0%
J1h, K3a	Fever and Weight Loss	2	0	0%

**RUG-III String Combinations** 21

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	uary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
B1	Comatose	0	0	0	1	0	1	0	2	0.0%
B2a	ST memory	0	6	55	224	45	144	100	374	26.7%
B4	Decision Making	3	7	65	235	54	150	122	392	31.1%
C4	Making Self Understood	4	7	38	128	46	102	88	237	37.1%
E1a	Negative statements (30)	0	0	1	6	1	1	2	7	28.6%
E1b	Repet questings(30)	1	1	2	6	1	2	4	9	44.4%
E1c	Repet verbalizations (30)	0	1	5	13	4	7	9	21	42.9%
E1d	Persistent anger (30)	1	3	5	21	3	10	9	34	26.5%
E1e	Self deprecation (30)	0	0	0	0	0	0	0	0	0.0%
E1f	Unrealistic fears (30)	0	0	4	6	1	2	5	8	62.5%
E1g	Recurrent statements (30)	0	0	3	5	0	0	3	5	60.0%
E1h	Repet health complaints	1	2	6	22	5	8	12	32	37.5%
E1i	Repet anxious complaints	2	3	4	21	7	11	13	35	37.1%
E1j	Unpleasant mood/AM (30)	1	3	5	13	0	2	6	18	33.3%
E1k	Insomnia/change pattern	0	2	4	8	1	3	5	13	38.5%
E1I	Sad/pained/worried facial	4	4	11	40	10	16	25	60	41.7%
E1m	Crying/tearfulness (30)	2	2	0	3	2	4	4	9	44.4%
E1n	Repetitive movements (30)	1	2	6	19	6	14	13	35	37.1%
E1o	Withdrawal/activities (30)	0	0	6	19	5	13	11	32	34.4%
E1p	Reduced social (30)	1	1	9	25	6	17	16	43	37.2%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
E4aA	Wandering	1	1	3	6	1	2	5	9	55.6%
E4bA	Verbally abusive	2	3	0	7	3	4	5	14	35.7%
E4cA	Physically abusive	0	0	0	0	1	2	1	2	50.0%
E4dA	Socially inapprop	1	2	2	17	4	7	7	26	26.9%
E4eA	Resists Care	0	0	3	19	4	17	7	36	19.4%
G1aA	Bed mobility/SP	17	34	173	885	196	607	386	1,526	25.3%
G1aB	Bed mobility/S	15	34	113	885	137	607	265	1,526	17.4%
G1bA	Transfer/SP	17	34	186	885	210	607	413	1,526	27.1%
G1bB	Transfer/SP	17	34	103	885	145	607	265	1,526	17.4%
G1hA	Eating/SP	21	34	195	885	225	607	441	1,526	28.9%
G1iA	Toilet use/SP	22	34	227	885	245	607	494	1,526	32.4%
G1iB	Toilet use/SP	18	34	124	885	141	607	283	1,526	18.5%
НЗа	Toileting plan (14)	4	4	20	24	6	15	30	43	69.8%
H3b	Bladder retrain prog (14)	0	0	0	0	2	3	2	3	66.7%
l1a	Diabetes	0	1	0	19	0	13	0	33	0.0%
l1r	Aphasia	0	0	13	44	2	17	15	61	24.6%
l1s	Cerebral palsy	0	2	0	14	0	5	0	21	0.0%
l1v	Hemiplegia	0	1	8	85	4	52	12	138	8.7%
I1w	Multiple sclerosis	0	0	1	9	0	3	1	12	8.3%
l1z	Quadriplegia	0	0	1	13	1	5	2	18	11.1%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
I2e	Pneumonia	0	0	6	14	4	18	10	32	31.3%
I2g	Septicemia	0	0	4	8	2	2	6	10	60.0%
J1c	Dehydrated	1	1	2	4	1	1	4	6	66.7%
J1e	Delusions	2	3	3	17	5	11	10	31	32.3%
J1h	Fever	0	0	2	9	0	2	2	11	18.2%
J1i	Hallucinations	0	0	2	4	4	7	6	11	54.5%
J1j	Internal bleeding	0	0	3	5	3	4	6	9	66.7%
J1o	Vomiting	0	0	1	2	0	0	1	2	50.0%
КЗа	Weight loss (30/180)	0	0	0	1	0	1	0	2	0.0%
K5a	Parenteral IV	1	1	27	77	18	33	46	111	41.4%
K5b	Feeding tube	0	1	2	115	0	77	2	193	1.0%
K6a	Total calories (%) recei	0	1	10	115	8	77	18	193	9.3%
K6b	Average fluid intake (daily)	0	0	1	4	1	6	2	10	20.0%
M1a	Ulcers: Stage 1	0	1	3	15	7	12	10	28	35.7%
M1b	Ulcers: Stage 2	1	4	18	58	23	51	42	113	37.2%
M1c	Ulcers: Stage 3	0	0	6	15	9	20	15	35	42.9%
M1d	Ulcers: Stage 4	0	0	5	25	5	18	10	43	23.3%
M2a	Pressure ulcer	0	1	4	39	5	35	9	75	12.0%
M4b	Burns	0	0	0	0	0	0	0	0	0.0%
М4с	Open lesions	0	3	0	10	2	19	2	32	6.3%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ıary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
M4g	Surgical wounds	0	2	1	42	1	22	2	66	3.0%
М5а	Press relieving device/c	2	2	22	27	24	25	48	54	88.9%
M5b	Pressure relieving devic	0	5	25	48	26	54	51	107	47.7%
М5с	Turn/reposition prog	3	3	51	59	47	53	101	115	87.8%
M5d	Nutrition/hydration inte	4	5	14	51	19	59	37	115	32.2%
М5е	Ulcer care	0	5	3	76	5	67	8	148	5.4%
M5f	Surgical wnd care	0	2	2	36	2	20	4	58	6.9%
M5g	App of dressings OTTF	1	6	5	94	16	85	22	185	11.9%
M5h	App of oint/med OTTF	0	7	8	91	12	79	20	177	11.3%
M6b	Infection of foot	0	0	0	2	1	2	1	4	25.0%
М6с	Open lesions/foot	0	0	1	14	1	4	2	18	11.1%
M6f	Foot dressings	0	0	1	15	2	6	3	21	14.3%
N1a	Time Awake: AM	0	0	0	1	0	1	0	2	0.0%
N1b	Time Awake: noon	0	0	0	1	0	1	0	2	0.0%
N1c	Time Awake: PM	0	0	0	1	0	1	0	2	0.0%
O3	Injections (# days)	0	1	3	19	4	13	7	33	21.2%
P1aa	Chemotherapy (14)	0	0	1	5	1	1	2	6	33.3%
P1ab	Dialysis (14)	0	0	1	14	0	6	1	20	5.0%
P1ac	IV med (14)	0	2	8	128	12	66	20	196	10.2%
P1ag	Oxygen therapy (14)	0	0	5	71	6	42	11	113	9.7%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	uary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P1ah	Radiation (14)	0	0	0	1	2	6	2	7	28.6%
P1ai	Suctioning (14)	0	0	2	9	1	7	3	16	18.8%
P1aj	Trach care (14)	0	0	0	8	1	7	1	15	6.7%
P1ak	Transfusions (14)	1	1	3	17	1	5	5	23	21.7%
P1al	Ventilator (14)	0	0	0	0	0	2	0	2	0.0%
P1baA	ST/days	0	1	2	46	6	49	8	96	8.3%
P1baB	ST/minutes	0	1	3	46	13	49	16	96	16.7%
P1bbA	OT/days	0	3	9	125	16	92	25	220	11.4%
P1bbB	OT/minutes	0	3	18	125	19	92	37	220	16.8%
P1bcA	PT/days	0	5	11	131	18	102	29	238	12.2%
P1bcB	PT/minutes	1	5	18	131	22	102	41	238	17.2%
P1bdA	RT/days	0	0	2	6	4	7	6	13	46.2%
P3a	NR/PROM	3	3	13	18	8	15	24	36	66.7%
P3b	NR/AROM	2	2	33	51	17	22	52	75	69.3%
P3c	NR/Splint or brace	2	2	5	7	2	2	9	11	81.8%
P3d	NR/Bed mobility	0	0	5	5	7	7	12	12	100.0%
P3e	NR/Transfer	1	1	11	18	11	12	23	31	74.2%
P3f	NR/Walking	1	1	10	25	5	11	16	37	43.2%
P3g	NR/Dressing	3	3	29	33	16	17	48	53	90.6%
P3h	NR/Eating	2	2	16	20	5	10	23	32	71.9%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		January		February		Mar	ch	Total		
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P3i	NR/Prosthesis care	0	0	0	0	0	0	0	0	0.0%
P3j	Communication	0	0	0	1	1	1	1	2	50.0%
P7	Physician Visits (14)	0	2	19	59	6	19	25	80	31.3%
P8	Physician Orders (14)	1	3	24	70	11	30	36	103	35.0%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P3d	NR/Bed mobility	0	0	5	5	7	7	12	12	100.0%
P3g	NR/Dressing	3	3	29	33	16	17	48	53	90.6%
М5а	Press relieving device/c	2	2	22	27	24	25	48	54	88.9%
М5с	Turn/reposition prog	3	3	51	59	47	53	101	115	87.8%
P3c	NR/Splint or brace	2	2	5	7	2	2	9	11	81.8%
P3e	NR/Transfer	1	1	11	18	11	12	23	31	74.2%
P3h	NR/Eating	2	2	16	20	5	10	23	32	71.9%
Н3а	Toileting plan (14)	4	4	20	24	6	15	30	43	69.8%
P3b	NR/AROM	2	2	33	51	17	22	52	75	69.3%
H3b	Bladder retrain prog (14)	0	0	0	0	2	3	2	3	66.7%
J1c	Dehydrated	1	1	2	4	1	1	4	6	66.7%
J1j	Internal bleeding	0	0	3	5	3	4	6	9	66.7%
P3a	NR/PROM	3	3	13	18	8	15	24	36	66.7%
E1f	Unrealistic fears (30)	0	0	4	6	1	2	5	8	62.5%
E1g	Recurrent statements (30)	0	0	3	5	0	0	3	5	60.0%
l2g	Septicemia	0	0	4	8	2	2	6	10	60.0%
E4aA	Wandering	1	1	3	6	1	2	5	9	55.6%
J1i	Hallucinations	0	0	2	4	4	7	6	11	54.5%
E4cA	Physically abusive	0	0	0	0	1	2	1	2	50.0%
J1o	Vomiting	0	0	1	2	0	0	1	2	50.0%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P3j	Communication	0	0	0	1	1	1	1	2	50.0%
M5b	Pressure relieving devic	0	5	25	48	26	54	51	107	47.7%
P1bdA	RT/days	0	0	2	6	4	7	6	13	46.2%
E1b	Repet questings(30)	1	1	2	6	1	2	4	9	44.4%
E1m	Crying/tearfulness (30)	2	2	0	3	2	4	4	9	44.4%
P3f	NR/Walking	1	1	10	25	5	11	16	37	43.2%
E1c	Repet verbalizations (30)	0	1	5	13	4	7	9	21	42.9%
M1c	Ulcers: Stage 3	0	0	6	15	9	20	15	35	42.9%
E1I	Sad/pained/worried facial	4	4	11	40	10	16	25	60	41.7%
K5a	Parenteral IV	1	1	27	77	18	33	46	111	41.4%
E1k	Insomnia/change pattern	0	2	4	8	1	3	5	13	38.5%
E1h	Repet health complaints	1	2	6	22	5	8	12	32	37.5%
E1p	Reduced social (30)	1	1	9	25	6	17	16	43	37.2%
M1b	Ulcers: Stage 2	1	4	18	58	23	51	42	113	37.2%
E1i	Repet anxious complaints	2	3	4	21	7	11	13	35	37.1%
E1n	Repetitive movements (30)	1	2	6	19	6	14	13	35	37.1%
C4	Making Self Understood	4	7	38	128	46	102	88	237	37.1%
E4bA	Verbally abusive	2	3	0	7	3	4	5	14	35.7%
M1a	Ulcers: Stage 1	0	1	3	15	7	12	10	28	35.7%
P8	Physician Orders (14)	1	3	24	70	11	30	36	103	35.0%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
E1o	Withdrawal/activities (30)	0	0	6	19	5	13	11	32	34.4%
E1į	Unpleasant mood/AM (30)	1	3	5	13	0	2	6	18	33.3%
P1aa	Chemotherapy (14)	0	0	1	5	1	1	2	6	33.3%
G1iA	Toilet use/SP	22	34	227	885	245	607	494	1,526	32.4%
J1e	Delusions	2	3	3	17	5	11	10	31	32.3%
M5d	Nutrition/hydration inte	4	5	14	51	19	59	37	115	32.2%
l2e	Pneumonia	0	0	6	14	4	18	10	32	31.3%
P7	Physician Visits (14)	0	2	19	59	6	19	25	80	31.3%
B4	Decision Making	3	7	65	235	54	150	122	392	31.1%
G1hA	Eating/SP	21	34	195	885	225	607	441	1,526	28.9%
E1a	Negative statements (30)	0	0	1	6	1	1	2	7	28.6%
P1ah	Radiation (14)	0	0	0	1	2	6	2	7	28.6%
G1bA	Transfer/SP	17	34	186	885	210	607	413	1,526	27.1%
E4dA	Socially inapprop	1	2	2	17	4	7	7	26	26.9%
B2a	ST memory	0	6	55	224	45	144	100	374	26.7%
E1d	Persistent anger (30)	1	3	5	21	3	10	9	34	26.5%
G1aA	Bed mobility/SP	17	34	173	885	196	607	386	1,526	25.3%
M6b	Infection of foot	0	0	0	2	1	2	1	4	25.0%
l1r	Aphasia	0	0	13	44	2	17	15	61	24.6%
M1d	Ulcers: Stage 4	0	0	5	25	5	18	10	43	23.3%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P1ak	Transfusions (14)	1	1	3	17	1	5	5	23	21.7%
О3	Injections ( # days)	0	1	3	19	4	13	7	33	21.2%
K6b	Average fluid intake (daily)	0	0	1	4	1	6	2	10	20.0%
E4eA	Resists Care	0	0	3	19	4	17	7	36	19.4%
P1ai	Suctioning (14)	0	0	2	9	1	7	3	16	18.8%
G1iB	Toilet use/SP	18	34	124	885	141	607	283	1,526	18.5%
J1h	Fever	0	0	2	9	0	2	2	11	18.2%
G1aB	Bed mobility/S	15	34	113	885	137	607	265	1,526	17.4%
G1bB	Transfer/SP	17	34	103	885	145	607	265	1,526	17.4%
P1bcB	PT/minutes	1	5	18	131	22	102	41	238	17.2%
P1bbB	OT/minutes	0	3	18	125	19	92	37	220	16.8%
P1baB	ST/minutes	0	1	3	46	13	49	16	96	16.7%
M6f	Foot dressings	0	0	1	15	2	6	3	21	14.3%
P1bcA	PT/days	0	5	11	131	18	102	29	238	12.2%
M2a	Pressure ulcer	0	1	4	39	5	35	9	75	12.0%
M5g	App of dressings OTTF	1	6	5	94	16	85	22	185	11.9%
P1bbA	OT/days	0	3	9	125	16	92	25	220	11.4%
M5h	App of oint/med OTTF	0	7	8	91	12	79	20	177	11.3%
l1z	Quadriplegia	0	0	1	13	1	5	2	18	11.1%
М6с	Open lesions/foot	0	0	1	14	1	4	2	18	11.1%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

		Janu	ary	Febru	ıary	Mar	ch		Total	
Item	Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
P1ac	IV med (14)	0	2	8	128	12	66	20	196	10.2%
P1ag	Oxygen therapy (14)	0	0	5	71	6	42	11	113	9.7%
K6a	Total calories (%) recei	0	1	10	115	8	77	18	193	9.3%
I1v	Hemiplegia	0	1	8	85	4	52	12	138	8.7%
I1w	Multiple sclerosis	0	0	1	9	0	3	1	12	8.3%
P1baA	ST/days	0	1	2	46	6	49	8	96	8.3%
M5f	Surgical wnd care	0	2	2	36	2	20	4	58	6.9%
P1aj	Trach care (14)	0	0	0	8	1	7	1	15	6.7%
M4c	Open lesions	0	3	0	10	2	19	2	32	6.3%
М5е	Ulcer care	0	5	3	76	5	67	8	148	5.4%
P1ab	Dialysis (14)	0	0	1	14	0	6	1	20	5.0%
M4g	Surgical wounds	0	2	1	42	1	22	2	66	3.0%
K5b	Feeding tube	0	1	2	115	0	77	2	193	1.0%
B1	Comatose	0	0	0	1	0	1	0	2	0.0%
E1e	Self deprecation (30)	0	0	0	0	0	0	0	0	0.0%
I1a	Diabetes	0	1	0	19	0	13	0	33	0.0%
I1s	Cerebral palsy	0	2	0	14	0	5	0	21	0.0%
КЗа	Weight loss (30/180)	0	0	0	1	0	1	0	2	0.0%
M4b	Burns	0	0	0	0	0	0	0	0	0.0%
N1a	Time Awake: AM	0	0	0	1	0	1	0	2	0.0%

#### MDS Item by Item Review Statistics Reviews Completed for January 31, 2005 through March 11, 2005

	Janu	ary	Febru	ıary	Mar	ch		Total	
Item Name	Unsup	Total	Unsup	Total	Unsup	Total	Unsup	Total	Percent
Time Awake: noon	0	0	0	1	0	1	0	2	0.0%
Time Awake: PM	0	0	0	1	0	1	0	2	0.0%
Ventilator (14)	0	0	0	0	0	2	0	2	0.0%
NR/Prosthesis care	0	0	0	0	0	0	0	0	0.0%
	Time Awake: noon Time Awake: PM Ventilator (14)	Item Name         Unsup           Time Awake: noon         0           Time Awake: PM         0           Ventilator (14)         0	Time Awake: noon         0         0           Time Awake: PM         0         0           Ventilator (14)         0         0	Item Name         Unsup         Total         Unsup           Time Awake: noon         0         0         0           Time Awake: PM         0         0         0           Ventilator (14)         0         0         0	Item Name         Unsup         Total         Unsup         Total           Time Awake: noon         0         0         0         1           Time Awake: PM         0         0         0         1           Ventilator (14)         0         0         0         0	Item Name         Unsup         Total         Unsup         Total         Unsup           Time Awake: noon         0         0         0         1         0           Time Awake: PM         0         0         0         1         0           Ventilator (14)         0         0         0         0         0	Item Name         Unsup         Total         Unsup         Total         Unsup         Total           Time Awake: noon         0         0         0         1         0         1           Time Awake: PM         0         0         0         1         0         1           Ventilator (14)         0         0         0         0         0         2	Item Name         Unsup         Total         Unsup         Total         Unsup         Total         Unsup           Time Awake: noon         0         0         1         0         1         0           Time Awake: PM         0         0         1         0         1         0           Ventilator (14)         0         0         0         0         0         2         0	Item Name         Unsup         Total         0         2           Time Awake: PM         0         0         0         1         0         1         0         2           Ventilator (14)         0         0         0         0         0         2         0         2

#### Summary Report of the Number of Facility Issues Noted and Reported Following the Review

	Category	Number of Occurences	Facilities
1	A3a Date	1	1.9%
2	Impaired Cognition (B2a, B4 or C4)	41	77.4%
3	Sad Mood/Depression (E1)	22	41.5%
4	Behavior Problems (E4)	21	39.6%
5	ADL (G1)	50	94.3%
6	Scheduled Toileting/Programs (H3a/b only)	9	17.0%
7	Diagnosis (I1)	21	39.6%
8	TF Calories (K6a)	10	18.9%
9	Ulcer/Pressure Ulcer (M1 or M2a)	28	52.8%
10	Open Lesions/Surgical Wounds (M4c,g)	5	9.4%
11	Applications of Dressings/Ointments (M5g,h)	18	34.0%
12	Pressure Relieving Device (M5a,b)	31	58.5%
13	Turning and Repositioning Program (M5c)	34	64.2%
14	Nutrition/Hydration Intervention (M5d)	21	39.6%
15	MDS Items Requiring Administration Documentation O2, Suction, Trach Care (P1ag, P1ai, P1aj)	23	43.4%
16	Dialysis (P1ab)	0	0.0%
17	Licensed Therapy (P1b)	32	60.4%
18	Respiratory Therapy (P1bd)	3	5.7%
19	Nursing Restorative (P3)	21	39.6%
20	Physician Visit/Orders (P7/P8)	27	50.9%
21	Services with a Surgical Procedure	0	0.0%
22	Medical Records with Missing Dates	2	3.8%
23	Documentation from Hospital Stay	18	34.0%
24	Documentation Outside Period/Does not Exist/ Limited/Unable to Provide	38	71.7%

Number of Facilities Reviewed

53

Percent of Facilities who were Greater than 40% Unsupported

23%

## **Louisiana Nursing Home Association And**

#### Department of Health and Hospitals Case Mix Review Issues and Findings May 2005 Training

Following the facility review the RN will indicate issues and findings associated with the following categories. These areas are noted on the exit conference form by categories. Reviewed facilities will receive the narrative description that applies to the review findings on the summary 10-day letter.

#### 1-A3a Date

Documentation was routinely found dated after the end of observation date (A3a). Since the A3a date marks the end of observation, any documentation reported after the A3a date exceeds the window of supporting documentation requirement unless otherwise stated. The A3a date controls what care and services are captured on the MDS assessment. See pages 3-29 through 3-31 of the RAI manual.

#### 2-Impaired Cognition (B2a, B4 or C4)

Either examples and/or frequency specificity were not provided in the medical record to support cognition impairment (B2a, B4 or C4). Specific resident examples and frequency are required for short-term memory, decision-making, and making self-understood. See the MDS Supportive Documentation Guidelines.

#### \_3-Sad Mood/Depression (E1)

Either examples and/or frequency specificity were not provided in the medical record to support depression, sad mood or anxiety. Specific resident examples and frequency are required for expressions of depression, sad mood or anxiety. See pages 3-60 through 3-64 of the RAI manual.

#### 4-Behavior Problems (E4)

Either examples and/or frequency specificity were not provided in the medical record to support behavior symptoms. Specific resident examples and frequency are required for expressions of behavior symptoms, hallucinations and delusions. See pages 3-66 through 3-68 and 3-139 of the RAI manual.

#### 5-ADL (G1)

The ADL supporting documentation during the observation period was either missing or inconsistent with the coding on the MDS. ADL responses on the MDS must reflect the resident's functionality during all shifts of the observation period. See pages 3-76 through 3-100 of the RAI manual.

#### 6-Scheduled Toileting/Programs (H3a/b only)

There was insufficient supporting documentation for a scheduled toileting plan or bladder retraining program. Documentation must include an organized, planned, documented, monitored and evaluated process. Documentation must also include resident's response to the program. Changing wet garments is not included in this concept. See pages 3-124 through 3-125 of the RAI manual and the Supportive Documentation Guidelines.

#### 7-Diagnosis (I1)

One or more active physician diagnosis was missing from the medical record or the diagnosis was not supported during the observation period. See pages 3-127 through 3-132 of the RAI manual.

#### 8-TF Calories (K6a)

The portion of total calories received by a resident through a feeding tube was not provided in the resident record. Calories are required to be reported as the percent of calories actually ingested in the last seven days. This requires documentation to report the calories required by the resident and the portion of total calories received through the tube feeding to support the percent of total calories ingested. See pages 3-155 through 3-156 of the RAI manual.

#### 9- Ulcer/Pressure Ulcer (M1 or M2b)

Ulcer staging was either not available or did not always support the MDS submission values. Pressure ulcers must be reverse staged on the MDS during the observation period. See pages 3-159 through 3-162 of the RAI manual.

#### \_\_\_10-Open lesions/Surgical Wounds (M4c,g)

Supporting documentation was either insufficient or not available to verify the presence of an open lesion or surgical wound. See pages 3-165 through 3-166 of the RAI manual.

#### \_11-Applications of Dressings/Ointments (M5g,h)

Evidence of any type of dressings or application of ointment was either insufficient or not available. See pages 3-167 through 3-168 of the RAI manual.

#### \_\_12-Pressure Relieving Device (M5a,b)

One or more pressure relieving device(s) had insufficient supporting documentation in the medical record or was not recorded at least once during the observation period. Pressure reducing is not considered synonymous with pressure relieving. See pages 3-167 through 3-168 of the RAI manual.

#### 13 – Turning and repositioning program

There was insufficient supporting documentation for a turning and repositioning program. Documentation must include evidence of "a specific approach that is organized, planned, documented, monitored, and evaluated". Documentation should also include resident's response to the program. See pages 3-167 to 3-168 of the RAI manual and the MDS Supportive Documentation Guidelines.

#### 14-Nutrition/Hydration Intervention (M5d)

Nutrition or hydration intervention to manage skin problems is defined as dietary measures received by the resident for the purpose of preventing or treating specific skin conditions and must be stated as such in the medical record. See pages 3-167 through 3-168 of the RAI manual.

### \_\_\_\_15-MDS Items Requiring Administration Documentation/O2, Suction, Trach Care (P1ag, P1ai, P1aj)

One or more MDS items were coded on the MDS without supporting documentation to verify the administration of the item coded. Examples include but are not limited to suctioning, oxygen administration and tracheostomy care. See the MDS Supportive Documentation Guidelines.

#### 16-Dialysis (P1ab)

IV's, IV medications, and blood transfusions in conjunction with dialysis should not be coded under their respective MDS items. Documentation must include evidence that the procedure occurred during the observation period. See page 3-182 of the RAI manual.

#### 17-Licensed Therapy (P1b)

The licensed therapy days or minutes were not calculated correctly as reported on the MDS, or the supporting documentation did not match the reported values. Licensed therapy is defined as <u>direct</u> therapy services provided to the resident during the observation period. This does not include the initial evaluation time. See pages 3-185 through 3-189 of the RAI manual.

#### 18-Respiratory Therapy (P1bd)

The licensed respiratory therapy days or minutes was not calculated correctly as reported on the MDS, or the supporting documentation did not support the reported values or no supporting values were provided. Licensed respiratory therapy is defined as <u>direct</u> therapy services provided to the resident. This does not include the initial evaluation time. See pages 3-185 through 3-189 of the RAI manual.

#### 19-Nursing Restorative (P3)

The nursing restorative days reported on the MDS were not supported in the medical record and/or the five criterions defining a nursing restorative program had one or more components missing. See pages 3-191 through 3-195 of the RAI manual.

#### 20-Physician Visit/Orders (P7/P8)

Physician Visits and/or Physician Orders are required to be submitted on the MDS as the number of <u>davs</u> of visits and orders received, not number of visits and orders. See pages 3-204 through 3-206 of the RAI manual.

#### 21-Services with a Surgical Procedure

One or more services were coded on the MDS that were provided solely in conjunction with a surgical procedure such as IV, medications or ventilators. Surgical procedures include routine pre and post-operative procedures. See page 3-184 of the RAI manual.

#### 22-Medical Records with Missing Dates

Supporting documentation identified in the medical record was not dated and therefore not sufficient to support one or more MDS elements reviewed during the review process. Documentation necessary to support MDS elements during the review process must be dated during the observation period.

#### 23-Documentation from Hospital Stav

One or more MDS elements coded on the MDS reflect events that occurred in the hospital and lacked supporting documentation from the hospital stay during the observation period. Supporting documentation is required to verify MDS elements coded as a result of the residents hospital stay.

#### 24-Documentation outside period/doesn't exist/limited/unable to provide

Supporting documentation was either outside the observation period, was not available, was limited or the facility was unable to provide supporting documentation when requested. Documentation must be provided during the review process in order to fully disclose the extent of documentation necessary to verify the RUG-III classification for the assessment.

# "Revised" Supportive Documentation Guidelines

Effective with assessments dated (A3a) on or after 6/15/2005 Version 4, 5/1/2005

#### **Special Notes About Documentation**

- 1) Information contained in the clinical record must be consistent and cannot be in conflict with the MDS. Inconsistencies will be deemed unsupported.
- 2) The entire medical record is subject to review.
- 3) Standard Medical Record Documentation Requirements
  - Each page or individual document in the medical record must contain the resident's identification information. At a minimum, each page must include resident's name and complete date (mm/dd/yyyy).
  - Initials and signatures rules
    - Supportive documentation entries must be dated and their authors identified by a signature or initial
    - o Initials may never substitute when a full signature is required by law
    - o When initials are used to identify the author, there must be a corresponding full signature to authenticate the initial
    - o Full signatures should include first initial or name, last name and title/credential
    - Supportive documentation forms or tools that include entries completed by multiple staff
      members at different times must include dates and signatures or initials on the form or
      tool itself to clearly identify who completed each entry
    - When electronic signatures are used, there must be policies to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures

#### **Special Case Mix Review Information**

- 1) State Corrective Action Phase-In (ReRug all unsupported assessments when facility exceeds State threshold)
  - a. July 2004 June 2005
     b. July 2005 June 2006
     c. July 2006 June 2007 and beyond
     Greater than 40% Unsupported
     Greater than 35% Unsupported
     Greater than 25% Unsupported
- 2) Case mix assessment sample is equal to:
  - a. Primary sample 20% (minimum of 10 assessments) of the current Final CMI Report
  - b. Expanded sample 20% (minimum of 10 assessments) of the current Final CMI Report (required if primary sample is greater than 25% unsupported)
- 3) Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and will be assigned a RUG-III code of BC1, denoting delinquency.

	I	Element Listing of MDS RUG-III Items	
MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION STANDARDS
(page 3-42 to 3-43)	Comatose (7-day look back)	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	Requires active Dx of coma or persistent vegetative state, signed by the physician within the past 15 months.
(page 3-43 to 3-45)	Short-Term Memory  (7-day look back)	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. (E.g., can't describe breakfast meal or an activity just completed). If there is no positive indication of memory ability, documentation must be cited in the medical record. Identify the most representative level of function, not the highest.	Example(s) demonstrating short-term memory for this specific resident. One good example(s) within the observation period.
(page 3-46 to 3-47)	Cognitive Skills for Daily Decision Making  (7-day look back)	Evidence by example must be found in the medical chart of the resident's ability to actively make everyday decisions about tasks or activities of daily living, and not whether staff believes the resident might be capable of doing so. The intent of this item is to record what the resident is doing (performance).	Example(s) demonstrating degree of compromised daily decision making. Code reflects impairment level. One good example(s) within the observation period.
C4 (page 3-54)	Making Self Understood  (7-day look back)	Evidence by example of the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.	Example(s) demonstrating resident's degree of ability to make self-understood. Code reflects impairment level. One good example(s) within the observation period.
Е1а-р	Indicators of Depression, Anxiety, Sad Mood (Coded 1 or 2)	Examples of verbal and/or non-verbal expressions of distress i.e., depression, anxiety, and sad mood must be found in the medical chart irrespective of the cause. See MDS (E1) for specific details.  Code (1) exhibited at least once during the last 30 days but less than 6 days a wk.  Code (2) exhibited 6-7 days a wk.  Frequency may be determined by either a tracking tool or log, or by specific narrative	Example(s) demonstrating resident's specific sad mood, anxiety or depression indicator(s) must occur and be documented within the observation period. Frequency required within the 30-day period ending with the A3a date.
(page 3-61 to 3-63)	(30-day look back)	notes. If using narrative notes, would require a note for each incident.	

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION STANDARDS
E4a-e Col.A only (page 3-66 to 3-68)	Behavioral Symptoms (Coded 2 or 3)  (7-day look back)	Examples of the resident's behavior symptom patterns that cause distress to the resident, or are distressing or disruptive to facility residents or staff members.  Code (2) exhibited 4-6 days, but not daily Code (3) exhibited daily or more frequently i.e. multiple times each day  Frequency may be determined by either a tracking tool or log, or by specific narrative notes. If using narrative notes, would require a note for each incident.	Example(s) demonstrating resident's specific behavior symptoms must occur and be documented within the observation period. Frequency of behavior required within the 7-day period ending with the A3a date.
G1a,b,i	Physical Functioning	These four ADLs include bed mobility,	Documentation requires 24
Col. A,B and G1h,A	and Structural Problems	transfer, toileting, and eating and must be documented for the full observation period in	hours/7 days within the observation period while in
(page 3-76 to	ADLs	the medical chart for purposes of supporting the MDS responses. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	the facility. Must have signatures and dates to authenticate the services provided.  If using an ADL grid, key for self-performance and support provided must be equivalent to
3-100)	(7-day look back)		the MDS key.
H3a NURSING RESTORE SCORE ONLY (page 3-124 to 3-125)	Any Scheduled Toileting Plan  (14-day look back)	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding. Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored, and evaluated." Documentation must include an evaluation of the resident's response to the toileting program.	Requires 1) Program must be care planned 2) evidence that toileting (plan) occurred within the observation period and 3) documentation describing an evaluation of the resident's response to the program. The resident's response must be noted within the observation period.
NURSING RESTORE SCORE ONLY	Bladder Retraining Program	Evidence in the medical chart must support a retraining program where the resident is taught to delay urinating or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. Documentation must include an evaluation of the resident's response to the retraining program.	Requires 1) Program must be care planned 2) evidence that a retraining program occurred within the observation period and 3) documentation describing and evaluation of the resident's response to the program. The resident's
(page 3-124 to 3-125)	(14-day look back)		response must be noted within the observation period.

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION
			STANDARDS
(page 3-127)	Diabetes Mellitus  (7-day look back)	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Includes insulin-dependent and diet-controlled.	Active Dx. signed by the physician within the past 15 months.
Itr	Aphasia	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Aphasia is defined as a speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts, or understanding spoken or written language. Include aphasia due to CVA.This	Active Dx. signed by the physician within the past 15 months.
(page 3-128)  11s	(7-day look back) Cerebral Palsy	difficulty must be cited in the medical chart.  In order to code the MDS, an active physician diagnosis must be present in the medical chart with evidence of paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to	Active Dx. signed by the physician within the past 15 months.
(page 3-128)	(7-day look back)	cerebral palsy.	
(page 3-129)	Hemiplegia/ Hemiparesis  (7-day look back)	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Paralysis/partial paralysis of both limbs on one side of the body. Left or right-sided paralysis is acceptable as a diagnosis.	Active Dx. signed by the physician within the past 15 months. Left or right -sided weakness not included.
11w (page 3-129)	Multiple Sclerosis  (7-day look back)	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Chronic disease affecting the CNS with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.	Active Dx. signed by the physician within the past 15 months.
(page 3-129)	Quadriplegia (7-day look back)	In order to code the MDS, an active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	Active Dx. signed by the physician within the past 15 months. Quadriparesis is not acceptable. Spastic Quad secondary to CP may not be coded as Quadriplegia. Quadriplegia secondary to severe organic syndrome of Alzheimer's type is not acceptable.

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION
			STANDARDS
(page 3-135 to	Pneumonia	In order to code the MDS, an active physician diagnosis must be present in the medical chart. An inflammation of the lungs. Often there is a chest x-ray, medication order and notation of fever and symptoms.	Active Dx. signed by the physician. A hospital discharge note referencing pneumonia during hospitalization is not sufficient unless current within the
3-137)	(7-day look back)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	observation period.
(page 3-135 to	Septicemia	In order to code the MDS, an active physician diagnosis must be present in the medical chart and may be coded when blood cultures have been drawn but "results" are not yet confirmed. Septicemia is a morbid condition associated with bacterial growth in the blood. Urosepsis is not considered for MDS review	Active Dx. signed by the physician. A hospital discharge note referencing septicemia during hospitalization is not sufficient unless current within the observation period.
3-137)	(7-day look back)	verification.	
J1c	Dehydrated; output exceeds intake	Supporting documentation must include 2 or more of the following:  1) Takes in less than 1500 cc of fluid daily  2) One or more clinical signs of dehydration, included but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, abnormal lab values, etc.  3) Fluid loss that exceeds intake daily	Intake and Output records. Documented signs of dehydration. Must include 2 or more of the 3 dehydration indicators. A hospital discharge note referencing dehydration during hospitalization is not sufficient unless 2 of the 3 dehydration indicators are present within the observation period.
(page 3-138 to	(7.1.1.1.1)	A 1:	
3-140) <b>J1e</b>	(7-day look back) Delusions	A diagnosis of dehydration is <b>not</b> sufficient.  Evidence in the medical chart must describe examples of resident's fixed, false beliefs not shared by others even when there is obvious	Resident specific example(s) demonstrating at least one episode of delusion(s) within
(page 3-139)	(7-day look back)	proof or evidence to the contrary.	the observation period.
<b>J1h</b> (page 3-139)	Fever	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	Must be able to calculate baseline unless the temp is above 101 degrees.
J1i	(7-day look back) Hallucinations	Evidence in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any	Resident specific example(s) demonstrating at least one episode of hallucination(s) within the observation period.
(page 3-139)	(7-day look back)	real stimuli.	

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION STANDARDS
J1j	Internal Bleeding	Clinical evidence of frank or occult blood must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis. Nosebleeds that are easily controlled should not be coded as internal bleeding.	Does not include UA with positive RBC's, unless there is additional supporting documentation such as physician's note, nurses notes "observed bright red blood"
(page 3-139)	(7-day look back)		etc.
J10	Vomiting	Documented evidence of regurgitation of stomach contents; may be caused by any	Documented evidence of regurgitation of stomach
(page 3-140)	(7-day look back)	etiology.	contents.
КЗа	Weight Loss	Documented evidence in the medical chart of the resident's weight loss.  5% or more in last 30 days OR 10% or more in last 180 days	The first step in calculating weight loss is to obtain the actual weights for the 30-day and 180-day time periods from the clinical record. Calculate percentage based on the
(page 3-150 to 3-152)	(30 and 180-day look back)		actual weight. Do not round the weight.
K5a	Parenteral / IV	Include only fluids administered for nutrition or hydration such as:  • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently  • IV fluids running at KVO (Keep Vein Open)  • IV fluids administered via heparin locks  Do NOT include:  • IV medications  • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay  • IV fluids administered solely as flushes  • Parenteral/IV fluids administered during chemotherapy or dialysis  • IV fluids used to reconstitute medications for IV administration	Administration records must be available within the observation period. If administration outside of facility, must provide hospital administration record. or other evidence of administration. Must provide evidence of fluid being administered for nutrition or hydration.
(page 3-153 to 3-154)	(7-day look back)	(unless administered for nutrition or hydration)	

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION STANDARDS
<b>K5b</b> (page 3-153 to 3-154)	Feeding Tube  (7-day look back)	Documented evidence of a feeding tube that can deliver food/ nutritional substances/ fluids/medications directly into the gastrointestinal system.	Evidence of feeding tube delivering nutrition within the observation period.
(page 3-154 to 3-156)	Calorie Intake  (7-day look back)	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This does not include calories taken p.o.	Must know resident's calorie requirement to determine what % is received by feeding tube or IV. If resident is on a p.o. diet also, must document the % total calories that the tube provided within the observation period.
(page 3-156 to 3-158)	Average Fluid Intake  (7-day look back)	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation. The amount of fluid in an IV piggyback is included in the calculation.	Must be able to calculate average amount of fluid (cc) within the observation period.
M1a-d	Ulcers/Staging	Evidence of the number of skin ulcers at each stage, on any part of the body. For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Skin ulcers that develop because of circulatory problems, or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin ulcers related to diseases such as syphilis and cancer and surgical wounds are <b>not</b> coded here, but are included in Item M4. Skin tears/shears are <b>not</b> coded here (M1) unless pressure was a contributing factor.  • If an ulcer met the definition for more than one stage during the observation period, code the ulcer as it appeared in the time frame closest to the ARD  • If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the	Skin ulcers must be coded in terms of what is seen within the look back period.  Documentation must include staging of any type of skin ulcer within the observation period. If scab meets MI definition of "ulcer", stage as "2" in M1.
(page 3-159 to 3-161)	(7-day look back)	graft fails, continues to code it as a surgical wound until healed	

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION STANDARDS
M2a (page 3-161 to	Pressure Ulcer	Includes any skin ulcer caused by pressure resulting in damage of underlying tissues.  Record the highest stage caused by pressure resulting in damage of underlying tissues.  Pressure ulcers must be coded in terms of what is seen during the look back period.	Documentation must include pressure as cause of skin ulcer. Documentation must include staging of pressure ulcers in terms of what is seen (i.e. visible tissue) within the
3-164)	(7-day look back)		7-day observation period.
M4b (page 3-165)	Burns (7-day look back)	Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first-degree burns (changes in skin color only).	Documentation must support evidence of second or third degree burns within the observation period.
M4c	Open Lesions/Sores	Skin lesions must be documented in the medical chart. Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Documentation must include a description of what is seen within the observation period. Do not code skin tears or	Documentation must include a description of what is seen within the observation period.
(page 3-165)	(7-day look back)	cuts here.	
(page 3-166)	Surgical Wounds  (7-day look back)	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, etc. Does not include healed surgical sites or stomas, or lacerations that require suturing or butterfly closure as surgical wounds.  • Do not code a debrided skin ulcer as a surgical wound.  • If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continues to code it as a surgical wound until healed.	PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
M5a	Pressure Relieving	Includes gel, air, or other cushioning placed	Evidence proving pressure
	Device/chair	on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg	relieving, pressure reducing, and pressure redistributing devices. Documentation at
(page 3-167 to 3-168)	(7 day look back)	crate cushions.	least once within the
3-100)	(7-day look back)		observation period.

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION STANDARDS
M5b	Pressure Relieving	Includes air fluidized, low air loss therapy	Evidence proving pressure
	Device/bed	beds, flotation, water, or bubble mattress or	relieving, pressure reducing,
		pad placed on the bed. Include pressure	and pressure redistributing
		relieving, pressure reducing, and pressure	devices. Documentation at
(page 3-167 to		redistributing devices. Do not include egg	least once within the
3-168)	(7-day look back)	crate mattress.	observation period.
M5c	Turning/repositioning	Evidence of continuous, consistent program	Requires that 1) Program
	program	for changing the resident's position and	must be care planned 2)
		realigning the body. "Program" is defined as	recorded daily within the
		"a specific approach that is organized,	observation period and 3)
		planned, documented, monitored, and	documentation describing an
		evaluated".	evaluation of the resident's
			response to the program. The
(2000) 2 16740			resident's response must be
(page 3-167 to	(7 day look back)		noted within the observation
3-168) <b>M5d</b>	(7-day look back) Nutrition/hydration	Evidence of dietary intervention received by	period.  Intervention(s) to manage skin
MISU	intervention to manage	the resident for the purpose of preventing or	problems must be specified
	skin problems	treating specific skin conditions. Vitamins and	and purpose stated (i.e., to
	skiii prooteitis	minerals, such as Vit. C or Zinc, which are	promote wound healing, to
		used to manage a potential or active skin	manage skin problems, etc.) at
(page 3-167 to		problem, should be coded here.	least once within the
3-168)	(7-day look back)	processin, should be coded here.	observation period.
M5e	Ulcer Care	Includes any intervention for treating skin	Treatment (care) must be
		problems coded in M1, M2, and M4c.	recorded at least once within
		Examples include use of dressings, chemical	the observation period.
(page 3-167 to		or surgical debridement, wound irrigations,	
3-168)	(7-day look back)	and hydrotherapy.	
M5f	Surgical Wound Care	Includes any intervention for treating or	Treatment (care) must be
		protecting any type of surgical wound.	recorded at least once within
(page 3-167 to		Evidence of wound care must be documented	the observation period.
3-168)	(7-day look back)	in the medical chart.	To a facility of the state of t
M5g	Application of	Evidence of any type of dressing application	Treatment (care) must be
(maga 2 1674-	dressings; other than	(with or without topical medications) to the	recorded at least once within
(page 3-167 to 3-168)	to feet (7-day look back)	body.	the observation period.
M5h	Application of	Evidence includes ointments or medications	Treatment (care) must be
171311	ointments/medications	used to treat a skin condition.	recorded at least once within
	(other than to feet)	This item does not include ointments used to	the observation period.
(page 3-167 to	(omer man to rect)	treat non-skin conditions (e.g., nitropaste).	ine ooser variou perioa.
3-168)	(7-day look back)	tent non onin conditions (c.g., intropusio).	
M6b	Infection of the foot	Clinical evidence noted in the medical chart to	Signs and symptoms must be
		indicate signs and symptoms of infection of	recorded at least once within
(page 3-168 to		the foot. Ankle problems are not considered	the observation period.
3-169)	(7-day look back)	foot problems and should not be coded in M6.	<u>*</u>

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION STANDARDS
<b>M6c</b> (page 3-168 to	Open lesion on the foot	Evidence of cuts, ulcers, or fissures.	Cuts, ulcers or fissures must be recorded at least once within the observation period.
3-169)	(7-day look back)		F
<b>M6f</b> (page 3-168 to	Applications of Dressings (feet)	Evidence of dressing changes to the feet (with or without topical medication) must be documented in the medical chart.	Treatment (care) must be recorded at least once within the observation period.
3-169)	(7-day look back)	F.:1 C. C	
N1a,b,c (page 3-170 to 3-171)	Time Awake  (7-day look back)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer. (No more than a total of a one- hour nap during any such period)	Flow charts are not expected for information such as sleep and awake times.
03	Injections	Evidence includes the number of days during the seven-day observation period that the resident received any medication by subcutaneous, intramuscular, intradermal injection, antigen or vaccines. This does not include IV fluids or IV medications. For subcutaneous pumps, code only the number of	TB and flu injections included Do not count Vitamin B12 injections if given outside of observation period.
(page 3-178 to		days that the resident actually required a	
(page 3-182, 3-184)	(7-day look back)  Special Treatments, Procedures and Programs  (14-day look back)	subcutaneous injection to restart the pump.  Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post procedure recovery period. Surgical procedures include routine pre- and post-operative procedures.	
P1a,a	Chemotherapy	Includes any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment. Evidence must be cited in the medical chart.	If administered outside of facility, evidence of administration record must be provided within the
(page 3-182)	(14-day look back)		observation period.
P1a,b	Dialysis	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical	Documentation must include evidence that procedure occurred within the
(page 3-182)	(14-day look back)	chart.	observation period.
P1a,c	IV Medication	Documentation of IV medication push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Do not include IV medications provided during chemotherapy or dialysis. Includes IV medications dissolved in a diluent as well as IV push medications.	Evidence of administration of IV med at least once within the observation period must be available. Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids, are included.
(page 3-182)	(14-day look back)	IV meds administered with procedure such as colonoscopy or endoscopy are not included.	

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION
20 0111101	220011111011	200000000000000000000000000000000000000	STANDARDS
P1a,g (page 3-183 to	Oxygen Therapy	Oxygen therapy shall be defined as the administration of oxygen continuously or intermittently via mask, cannula, etc. Evidence of administration must be cited on the medical chart. (Does not include	Evidence of administration of oxygen at least once within the observation period must be provided.
3-184)	(14-day look back)	hyperbaric oxygen for wound therapy.)	10 1 1 1 1
P1a,h (page 3-183)	Radiation (14-day look back)	Evidence includes radiation therapy or a radiation implant.	If administered outside of facility, evidence of procedure occurring within the observation period must be provided.
P1a,i	Suctioning	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. Oral suctioning is not permitted to be coded in	Nasopharyngeal or tracheal aspiration must be present at least once within the
(page 3-183)	(14-day look back)	this field.	observation period.
P1a,j (page 3-183)	Tracheostomy Care  (14-day look back)	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	Evidence must support cannula cleansing by staff at least once within the observation period. Changing a disposable cannula is included.
P1a,k	Transfusions	Evidence of transfusions of blood or any	Evidence of transfusions of
(page 3-183)	(14-day look back)	blood products administered directly into the bloodstream by staff must be cited in the medical chart. Do not include transfusions that were administered during chemotherapy or dialysis.	blood or any blood products administered directly into the bloodstream by staff at least once within the observation period must be present.
P1a,l	Ventilator or	Includes any type of electrically or	Does not include CPAP or
( 2 102 1	Respirator	pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off the ventilator or respirator in the	BiPAP in this field.
(page 3-183 to 3-184)	(14 day look haak)	last 14 days should be coded. Does not include CPAP or BiPAP in this field.	
3-184)	(14-day look back)	include CPAP of BIPAP in this field.	

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION
20 0.11101	22011111011		STANDARDS
P1b	Therapies	Days and minutes of each therapy must be	Direct therapy days and
a,b,c		cited in the medical chart on a daily basis to	minutes with associated
Col. A,B		support the total days and minutes of direct	signature(s) must be provided.
		therapy provided. Includes only medically	Cannot count initial
		necessary therapies furnished after admission	evaluation time. Must provide
		to the nursing facility. Also includes <b>only</b>	evidence of physician order.
		therapies ordered by a physician, based on a	
		therapist's assessment and treatment plan that	
		is documented in the clinical record.	
		Group therapy is limited to four residents per	
		session and only 25% of the total therapy	
		minutes per discipline may be contributed to	
		group therapy (section P1b,a-c). Therapy	
		minutes provided simultaneously by two or	
		more therapists must be split accurately	
		between disciplines (section P1b,a-c). The	
		time it takes to perform an initial evaluation	
		and develop the treatment goals and the plan	
		of care for the resident cannot be counted as	
		minutes of therapy received by the resident.	
(page 3-185 to		Re-evaluations, once therapy is underway,	
3-190)	(7-day look back)	may be counted.	

MDS 2.0 LOCATION	FIELD DESCRIPTION	CASE MIX DOCUMENTATION GUIDELINES	MINIMUM DOCUMENTATION STANDARDS
P1b, d A	Respiratory Therapy	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. Includes only medically necessary therapies furnished after admission to the nursing facility. Also includes only therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. A trained nurse may perform the assessment and the treatments when permitted by the state practice act. *** In lieu of the Licensed Respiratory Therapist, a "Trained Nurse" (only the Registered Nurse in Louisiana)	Direct therapy days and minutes with associated signature(s) must be provided. Qualified individuals for the delivery of respiratory services include "trained nurses". A trained nurse refers to a nurse who received training on the administration of respiratory treatments and procedures. Must provide evidence of nurse training.
(page 3-185 to 3-190)	(7-day look back)	Assessments and subsequent assessments after being trained by a Licensed Respiratory Therapist. (per Health Standards)  Qualified professionals for the delivery of respiratory services include "trained nurses." A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training program.	

MDS 2.0	FIELD	CASE MIX	MINIMUM
LOCATION	DESCRIPTION	DOCUMENTATION GUIDELINES	DOCUMENTATION
LOCATION	DESCRIPTION	DOCCMENTATION GUIDELINES	STANDARDS
P3a-j	Nursing	Days of restorative nursing must be cited in	Documentation must meet the
NURSING	Rehab/Restorative	the medical chart on a daily basis. Minutes of	five criteria of a nursing
RESTORE	Renao/Restorative	service must be provided daily to support the	restorative program. Direct
SCORE		program and total time that is then converted	restorative days and minutes
ONLY		to days on the MDS. Documentation must	with associated signature (s)
ONLI		meet the five criteria of a nursing restorative	and date(s) must be provided.
		program.	Active ROM includes Active
		Dentures are <b>not</b> considered to be prostheses	Assisted ROM.
		for coding this item.	Must specify either Active or
		Nursing rehabilitation/restorative care	Passive ROM. "ROM" is not
		includes nursing interventions that assist or	sufficient for the review.
		promotes the resident's ability to attain his or	sufficient for the review.
		her maximum functional potential. It does not	
		include procedures under the direction and	
		delivery of qualified, licensed therapists.	
		Nursing Restorative criteria must be met as	
		defined on page 3-192 of the RAI manual.	
		defined on page 3 172 of the 14 if manual.	
		The five criteria required to constitute a	
		nursing restorative program are:	
		1). Care plan with measurable objectives and	
		interventions	
		2). Periodic evaluation by a licensed nurse	
		3). Staff trained in the proper techniques	
		4). Supervision by nursing	
(page 3-191 to		5). No more than 4 residents per supervising	
3-195)	(7-day look back)	staff personnel	
P7	Physician visits	Evidence includes the <b>number of days</b> (NOT	Must include documentation
	,	NUMBER OF VISITS) in the last 14 days a	establishing an exam by the
		physician examined the resident. Can occur in	physician to be counted as a
		the facility or in the physician's office. A	visit.
(page 3-204 to		licensed psychologist may not be included for	
3-205)	(14-day look back)	a visit.	

MDS 2.0	FIELD	CASE MIX	MINIMUM
<b>LOCATION</b>	DESCRIPTION	DOCUMENTATION GUIDELINES	<b>DOCUMENTATION</b>
			STANDARDS
P8	Physician orders	Evidence includes the <b>number of days</b> (NOT	Documentation must include
		NUMBER OF ORDERS) in the last 14 days a	evidence of days with new or
		physician changed the resident's orders.	altered physician orders.
		Includes written, telephone, fax, or	
		consultation orders for new or altered	
		treatment. Does not include standard	
		admission orders, return admission orders,	
		renewal orders, or clarifying orders without	
		changes. A licensed psychologist may not be	
		included for an order. Orders written on the	
		day of admission as a result of an unexpected	
		change/deterioration in condition or injury are	
		considered as new or altered treatment orders	
(page 3-205 to		and should be counted as a day with order	
3-206)	(14-day look back)	changes.	

### **Restorative Nursing Defined for Case Mix**

Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when a restorative need arises during the course of a custodial stay and they are not a candidate for a more formalized therapy program. Restorative nursing is a nursing function and does not require a physician's order or oversight by a licensed therapist. Assessment skills are crucial. To remain in a restorative nursing program, the resident must maintain or retain level of functioning. In addition, rehabilitation or restorative care **must meet all of the following criteria:** 

- The <u>individual</u> problem must be clearly identified (ex. AROM, splint or brace assistance, transfer, walking, grooming, etc.)
- Measurable goals (objectives) and measurable interventions (actions) are clearly documented (care planned) for each individual program. (For something to be measurable it must have a particular unit of measurement attached to it, e.g. a timescale, a weight or a distance and it must be measured against a particular goal or standard).

Goals should be 'specific, reasonable, moderately challenging and attainable within a short space of time'. These short-term goals should be seen in the context of long-term achievement. Cannot include "canned" or "one-size-fits-all" "pre-printed" care plan for each program. These do not address the individual or their needs.

- A periodic evaluation by a licensed nurse is present in the resident's record for each individual restorative program
- Nurse assistants/aides are trained in the techniques that promote resident involvement in the activity
- The activities are supervised by a licensed nurse, although these interventions may be carried out by nurse assistants/aides, other staff or volunteers,
- Groups with more than four residents per supervising helper or caregiver are not included
- The technique, procedure or activity practiced total at least 15 minutes during a 24-hour period to report one day of restorative.

### Documentation Requirements for Case Mix:

The Restorative Nurse must care plan each problem; establish measurable goals and measurable interventions specific to each individual resident.

The MDS requires each technique, procedure or activity practiced totals a minimum of 15 minutes during a 24-hour period. For the RUG-III classification at least six of the seven days during the observation period must be reported for **each** problem addressed. The case mix reviewers are required to review actual minutes provided each day and signed by the staff providing the service.

Interventions may be carried out by nurse assistants/aides, or other staff or volunteers. However, a periodic evaluation of each problem the resident is receiving restorative services for must be documented by a licensed nurse.

Prepared by DHH 4/15/2004

R	esto	orat	tive	Ca	re/	Sch	iedi	uleo	T f	oile	tin	g/T	urr	ning	g an	d I	Rep	osi	tior	ning	Ca	are	Pla	n a	nd	Flo	w l	Rec	ord	l	
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### Restorative Care/Scheduled Toileting/Turning and Repositioning Care Plan and Flow Record

#### **Nursing Restorative Services: Nursing Restorative Criteria:** \*To be included in this section, a nursing rehabilitation or restorative practice must meet all of H3a\* Any scheduled toileting plan the following additional criteria: Bladder retraining program H3b\* \*Measurable objectives and interventions must be documented in the care plan and in the Range of motion (passive) P3a\* P3b\* Range of motion (active) clinical record \*Evidence of periodic evaluation by licensed nurse must be present in the clinical record. Splint or brace assistance P3c \*Nurse assistants/aides must be trained in the techniques that promote resident involvement in P3d\* Bed mobility the activity. P3f\* Walking \*These activities are carried out or supervised by members of the nursing staff. P<sub>3</sub>e Transfer \*This category does not include groups with more than four residents per supervising helper P3g Dressing or grooming Eating or swallowing P3h or caregiver. P3i Amputation/prosthesis care P3i Communication \*Count as one service (H3a and b; P3a and b; P3d and f) even if both provided Documentation checkpoint Documentation checkpoint No Are NR days and minutes complete, dated, signed and accurate? No Are the 5 NR criteria met? (see page 7, Nursing Restorative) Licensed Nurse evaluation of resident's response to program: Date: **Restorative Aide Notes:**

Resident Name	Medical Record Number	Medical Record Number

**RAI CLARFICATION: 02/2005** 

### **RAI Manual Section P1bd: Respiratory Therapy:**

In lieu of the Licensed Respiratory Therapist, a "Trained Nurse" (**only the Registered Nurse in LA**) may perform the Initial Respiratory Assessments and subsequent assessments after being trained by a Licensed Respiratory Therapist. The nurse may have also been trained in a special academic program, as well. For instance, a Registered Nurse (RN) took a special course on Respiratory Therapy and may have received some type of certification as a Certified Respiratory Therapy Nurse. There must be documentation to verify that the Registered Nurse received such training on the administration of respiratory treatment. The "Trained Nurse" may train other Registered Nurses to perform the assessments and evaluations.

NOTE: The trained Licensed RN must conduct those assessments (initial and subsequent) periodically and based on the needs of the resident and the treatment plan needs to be altered.

In order for the **trained** Licensed Registered Nurse, Licensed Practical/Vocational Nurse or Respiratory Therapist to claim those therapy minutes, there **must be** documented evidence of:

- An assessment
- Treatment plan
- Implementation of the treatment
- · Monitoring of the resident's condition
- Evaluation of the treatment plan.
- Physician's Order

**Example 1:** The **trained** RN, LPN or LVN prepares the nebulizer treatment, brings the set-up to the resident's room. The nurse gives the nebulizer to the resident and leaves the room. The nurse returns to the resident's room after the treatment is completed.

As per CMS instructions, this would not meet the definition of the intent for Respiratory Therapy Treatments.

**Example 2:** The **trained** RN, LPN or LVN prepares the nebulizer treatment, brings the set-up to the resident's room. The nurse administers the nebulizer treatment and remains in the resident's room, as she monitors the resident's condition and response to the treatment. The nurse documents the resident's condition and response to the treatment. The LPN/LVN must report untoward changes to the RN for further investigation. The **RN** will then conduct the assessment, make appropriate changes to the treatment plan and consult the physician, if applicable.

As per CMS instructions, this would meet the definition of the intent for Respiratory Therapy Treatments.

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# **Respiratory Therapy Evaluations and Flow Record**

dditional Nurse's notes:	
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Resident Name	Medical Record Number	Medical Record Number

# **CMI Reports**

### **LOUISIANA CASE MIX SYSTEM**

### **Final Case Mix Index Report**

Point in Time Date 01/01/2004

Print Date: 03/18/2004

Page: 1 of 3

Provider Number: 5bbbb

Provider Name: XYZ NURSING CENTER

Resident Name	SSN	Resident ID	AA8a,b	Effective Date (R2b)	RUG Code	RUG Category	Notes	Payment Source	Index
			09	11/12/2003	SE2	Extensive Special Care 2 / ADL > 6	Α	Other	1.7900
			09	12/12/2003	PA1	Reduced Physical Function / ADL 4-5	Α	Medicaid	0.5900
			05	11/05/2003	SSA	Special Care / ADL 4-14		Medicaid	1.2800
			05	11/18/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			05	11/10/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			03	10/15/2003	CA2	Clinically Complex with Depression / ADL 4-11		Medicaid	1.0600
			01	12/30/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			05	10/22/2003	IB1	Cognitive Impairment / ADL 6-10		Medicaid	0.8500
			03	11/17/2003	CA2	Clinically Complex with Depression / ADL 4-11		Other	1.0600
			05	12/17/2003	PB1	Reduced Physical Function / ADL 6-8		Medicaid	0.6300
			05	10/22/2003	SSA	Special Care / ADL 4-14		Medicaid	1.2800
			00, 2	12/23/2003	SSA	Special Care / ADL 4-14		Medicare	1.2800
			05	11/10/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			05	12/24/2003	CB1	Clinically Complex / ADL 12-16		Medicaid	1.0700
			02	12/24/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			05	10/22/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			01	10/07/2003	PD1	Reduced Physical Function / ADL 11-15		Medicaid	0.8900
			05	10/22/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			00, 2	12/24/2003	RAA	Rehabilitation All Levels / ADL 4-9		Medicare	1.0700
			05	12/03/2003	PA1	Reduced Physical Function / ADL 4-5		Other	0.5900
			03	12/10/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			05	12/24/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			01	10/15/2003	IA1	Cognitive Impairment / ADL 4-5		Other	0.6700
			01	10/29/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			00, 2	12/10/2003	RAB	Rehabilitation All Levels / ADL 10-13		Medicare	1.2400
			03	11/17/2003	IB1	Cognitive Impairment / ADL 6-10		Medicaid	0.8500
			02	12/10/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			00, 2	12/12/2003	RAB	Rehabilitation All Levels / ADL 10-13		Medicare	1.2400
			09	10/31/2003	CB1	Clinically Complex / ADL 12-16	Α	Medicaid	1.0700
			05	11/24/2003	IB1	Cognitive Impairment / ADL 6-10		Other	0.8500
			05	12/01/2003	PE1	Reduced Physical Function / ADL 16-18		Medicaid	0.9700
			05	12/29/2003	IA1	Cognitive Impairment / ADL 4-5		Medicaid	0.6700
			03, 2	12/01/2003	RAA	Rehabilitation All Levels / ADL 4-9		Medicare	1.0700

### LOUISIANA CASE MIX SYSTEM

### **Final Case Mix Index Report**

Point in Time Date 01/01/2004

Print Date: 03/18/2004

Page: 2 of 3

**Provider Number: 5bbbb** 

Provider Name: XYZ NURSING CENTER

		Resident		Effective	RUG			Payment	
Resident Name	SSN	ID	AA8a,b	Date (R2b)	Code	RUG Category	Notes	Source	Index
			01	11/14/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			01	11/14/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			03	12/04/2002	BC1	Delinquent Assessment	F	Medicaid	0.5900
			00, 2	12/08/2003	SSC	Special Care / ADL 17-18		Medicare	1.4400
			05	10/29/2003	CA1	Clinically Complex / ADL 4-11		Medicaid	0.9500
			09	11/21/2003	BC1	Delinquent Assessment	D	Other	0.5900
			05	10/29/2003	PA1	Reduced Physical Function / ADL 4-5		Medicaid	0.5900
			00, 7	12/30/2003	SSB	Special Care / ADL 15-16		Medicare	1.3300

### **LOUISIANA CASE MIX SYSTEM**

### **Final Case Mix Index Report**

Point in Time Date 01/01/2004

Print Date: 03/18/2004

Page: 3 of 3

Provider Number: 5bbbb

Provider Name:	XYZ NURSING CEN	ITER							
Resident Name	SSN	Resident ID	AA8a,b	Effective Date (R2b)	RUG Code	RUG Category	Notes	Payment Source	Index
			03, 1	10/06/2003	SE2	Extensive Special Care 2 / ADL > 6		Medicare	1.7900
RUG Distribution	Totals						Total Residents	s and CMI Aver	ages
Extensive Services	2						Medicaid Resident	ts: 26	0.8473
Rehabilitation	4						Medicare Residen	ts: 8	1.3075
Special Care	5						Other Beetdenter		0.0000
Clinically Complex	9						Other Residents:	8	0.9063
Impaired Cognition	7								
Behavior Problems	0						Total Residents:	42	0.9462
Reduced Physical Function	on 13		<u>Note</u>	<u>es</u>					
Delinquent	2			nis reentry form is preceding assessn		ith an assessment that is active and	d is assigned the RUG	6-III code appli	cable to
Total Residents	42		D. Tr assiç		preceded by	y a Discharge Tracking form and no	other assessment. A	BC1 RUG-III c	ode is
				nis assessment is oting delinquency.		121 days from the R2b (completion	n date) and is assigne	d the RUG-III c	ode of BC1

### State of Louisiana Department of Health and Hospitals Note Field for Louisiana CMI Report

- A. This reentry form is preceded with an assessment that is active and is assigned the RUG-III code applicable to the preceding assessment.
- B. This reentry form is preceded with an assessment that is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.
- C. This reentry form has no assessment or record preceding this reentry and is assigned a BC1 RUG-III code.
- D. This reentry form is preceded by a Discharge Tracking form and no other assessment. A BC1 RUG-III code is assigned.
- E. This reentry is followed with a new assessment started within the calendar quarter but contains an R2b date later than the calendar quarter date. No RUG-III code is assigned.
- F. This assessment is greater than 121 days from the R2b (completion date) and is assigned the RUG-III code of BC1 denoting delinquency.
- R. This assessment's original RUG-III code has been replaced with a RUG-III code based on the documentation provided during the MDS review.

# State of Louisiana Department of Health and Hospitals RUG Distribution on CMI Report When Note Applied

Examples reference quarter 4/01/year

CMI			
Report NOTE	Note Description	Assessment Scenario	Assessment and RUG-III Display on CMI Report
A	This reentry form is preceded with an	Quarterly Assessment 1/30/year CA1	Reentry Tracking Form 3/12/year
	assessment that is active and is assigned the	Discharge Tracking 3/10/year	
	RUG-III code applicable to the preceding	Reentry Tracking 3/12/year	CA1
	assessment.	End of Quarter 4/01/year	
В	This reentry form is preceded with an	Admission Assessment 11/10/year PC2	Reentry Tracking Form 3/12/year
	assessment that is greater than 121 days from	Discharge Tracking 3/10/year	
	the R2b (completion date) and is assigned the	Reentry Tracking 3/12/year	BC1
	RUG-III code of BC1 denoting delinquency.	End of Quarter 4/01/year	
С	This reentry form has no assessment or record	No Assessment	Reentry Tracking Form 3/18/year
	preceding this reentry and is assigned a BC1	Reentry Tracking 3/18/year	
	RUG-III code.	End of Quarter 4/01/year	BC1
		No Assessment	
D	This reentry form is preceded by a Discharge	No Assessment	Reentry Tracking Form 3/18/year
	Tracking form and no other assessment. A	Discharge Tracking Form 3/12/year	
	BC1 RUG-III code is assigned.	Reentry Tracking 3/18/year	BC1
		End of Quarter 4/01/year	
		No Assessment	
Е	This reentry is followed with a new	Reentry Tracking 3/29/year	Reentry Tracking Form 3/29/year
	assessment started within the calendar quarter	Annual Assessment (R2b 4/11/year)	
	but contains an R2b date later than the		No RUG-III Assignment
	calendar quarter date. No RUG-III code is		
	assigned.		

# **RUG Distribution on CMI Report When Note Applied**

### Continued

	F	This assessment is greater than 121 days from	Quarterly Assessment 10/3/year IB2	Quarterly Assessment Form 10/3/year
		the R2b (completion date) and is assigned the	No subsequent assessments	
		RUG-III code of BC1 denoting delinquency.	End of Quarter 4/01/year	BC1
ſ	R	This assessment's original RUG-III code has	Quarterly Assessment 3/25/year (IB2)	Quarterly Assessment
		been replaced with a RUG-III code based on	Case Mix Review	
		the documentation provided during the MDS	Quarterly Assessment 3/25/year (PB1)	PB1
		review.	End of Quarter 4/01/year	

# **General CMI Report Assessment Issues**

CMI Report Findings	CMI Report Considerations	CMI Actions
Resident assessment	Verify if resident was discharged	Transmit Discharge Tracking form
displayed on CMI report and	2. Verify that all resident identifying	2. Correct any inaccurate resident identifying
shouldn't be.	information is correct	information and retransmit assessment
Resident assessment not displayed on CMI report and	1. Verify that most recent assessment was transmitted.	Transmit most recent assessment
should be.	<ol><li>Verify that Reentry Tracking form was transmitted.</li></ol>	2. Transmit Reentry form
	<ol><li>Admission assessment was never transmitted.</li></ol>	3. Transmit Admission assessment
	4. Assessment was rejected by the State.	4. Correct error and retransmit
	5. Verify that all resident identifying	5. Correct any inaccurate resident identifying
	information is correct.	information and retransmit assessment
Resident assessment	1. Greater than 121 days have passed	Do nothing if no assessment
displayed on CMI report	without another transmitted assessment	If assessment completed, transmit
with a BC1 RUG code.	2. Resident has reentered and the preceding	2. Do nothing
	assessment is greater than 121 days old	If assessment completed, transmit
	and no new assessment was completed	
	within 14 days of the reentry date.	
	3. The reentry tracking form has no preceding assessment	3. Do nothing
Same resident displayed on	1. One or more of the resident identifiers	Correct any inaccurate resident identifying
CMI report with two	has been transmitted with inaccurate data	information and retransmit assessment
different assessments.		
Resident assessment	1. One or more of the resident identifiers	Correct any inaccurate resident identifying
displayed on CMI report but	has been transmitted with inaccurate data	information and retransmit assessment
is not the correct assessment.	2. A later assessment was not transmitted.	2. Transmit assessment
	3. A later assessment was transmitted but rejected by the State	3. Correct any inaccuracy and retransmit assessment

# State of Louisiana Department of Health and Hospitals Case Mix Index Report Process

# **Assessment Transmission Due Date and Report Due Date**

MDS assessments completed with an R2b date on or before the point in time date provided on the CMI Report	Assessments transmitted Prior to:	CMI Report Type	Rate for Quarter
(CMI Report dated 10-01-year) July, August, September	November 1	November 15 Preliminary	January February
Assessments	December 1	December 15 Final	March
(CMI Report dated 01-01-year) October, November, December	February 1	February 15 Preliminary	April
Assessments	March 1	March 15 Final	May June
(CMI Report dated 04-01-year)	May 1	May 15 Preliminary	July
January, February, March Assessments	June 1	June 15 Final	August September
(CMI Report dated 07-01-year)	August 1	August 15 Preliminary	October
April, May, June Assessments	September 1	September 15 Final	November December

### Louisiana Department of Health and Hospitals – CMI Listing Report and Transmission Schedule

January 2005											
S	S M T W T F S										
						1					
2	3	4	5	6	7	8					
9	10	11	12	13	14	15					
16	17	18	19	20	21	22					
23 30	24 31	25	26	27	28	29					

February 2005										
S	S M T W T F S									
		1	2	3	4	5				
6	7	8	9	10	11	12				
13	14	15	16	17	18	19				
20	21	22	23	24	25	26				
27	28									

	March 2005											
S	S M T W T F S											
		1	2	3	4	5						
6	7	8	9	10	11	12						
13	14	15	16	17	18	19						
20	21	22	23	24	25	26						
27	28	29	30	31								

Final date for MDS
transmission for the
Preliminary CMI Listin
Report

April 2005										
S	M T W T F S									
					1	2				
3	4	5	6	7	8	9				
10	11	12	13	14	15	16				
17	18	19	20	21	22	23				
24	25	26	27	28	29	30				

		M	ay 20	05		
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1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

		Ju	ne 20	05		
S	M	T	W	Т	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

		Jı	ıly 20	05		
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24 31	25	26	27	28	29	30

		Au	gust 2	2005		
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7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

		Sept	embe	r 200	5	
S	M	T	W	T	F	S
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

		Sept	CIIIDC			
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	5	6	7	8	9	10
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_	19	20	21	22	23	24
	26	27	28	29	30	
				-		1

		Oct	ober 2	2005		
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						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23 30	24 31	25	26	27	28	29

		Nove	mber	2005		
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

		Dece	mber	2005		
1S	M	T	W	Т	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Tan Day of Month

**Blue Day of Month** Date that the Preliminary CMI Listing Reports are mailed to Providers (usually the 15<sup>th</sup> day of the month)

Green Day of the Month Final date for MDS transmission for the Final CMI Listing Report

> Month of the Report.

vith an R2b this date will be listed

### **Rose Day of Month**

Date that the Final CMI Listing Reports are mailed to Providers (usually the 15<sup>th</sup> of the month)

# **ADL Samples**

# RUG-III, Version 5.12 Classification Model 34-Grouper

The RUG-III Classification system has seven major resident classification groups: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs. In the Extensive Services category, an extensive services count is completed to determine if the assessment also meets the criteria in Special Care, Clinically Complex and Impaired Cognition. In the Clinically Complex category, assessments are differentiated by the absence or presence of depression. And, in the Impaired Cognition, Behavior Problems and Reduced Physical Functions categories, two or more nursing restorative services are recognized. This guide translates the computer programming into words and has been carefully reviewed to insure that it represents the standard RUG-III logic.

One very important calculation in the classification process is the scoring of Activities of Daily Living (ADL). An ADL Score is calculated for all assessment classifications and is one of the determining factors regarding placement in a RUG-III category. The ADL Score calculation includes G1a (bed mobility), G1b (transfer), G1i (toilet use), and an eating calculation. The ADL Scores range between 4 and 18. An ADL Score of 4 represents the most independent resident while a score of 18 represents the most dependent resident.

Other ADLs are also very important, but the national researchers have determined that the late loss ADLs (bed mobility, transfer, eating, and toilet use) are more predictive of resource use. The researchers determined that including the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.

In the 34-group model there are 4 categories in the Rehabilitation group and different levels of rehabilitation service are not distinguished. The simplified Rehabilitation classification in the 34-group model is better suited to long-term care programs, which often classify on the basis of nursing care needs only. Medicaid long-term care programs in many States are examples. In the 34-group model, the Extensive Services groups have the highest level of nursing care needs, while the Rehabilitation groups have the next highest level of need. For this reason, the order of the Rehabilitation and Extensive Services groups are reversed in the 34-group model, with the Extensive Services groups first in comparison to the 44-group model.

### HIERARCHICAL VERSUS INDEX MAXIMIZING CLASSIFICATION

There are two basic approaches to RUG-III classification: hierarchical classification and index maximizing classification. This guide is focused on the hierarchical approach but can be adapted to the index maximizing approach. See below for a description of the two methodologies.

### **Hierarchical Classification**

Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top of the RUG-III hierarchy and stop at the first group for which the assessment qualifies. In other words, start with the Extensive Services groups at the top of the RUG-III model. Then work down through the groups in

hierarchical order: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems and Reduced Physical Functions. Assign the first of the 34 individual RUG-III groups for which the assessment qualifies as the RUG-III classification.

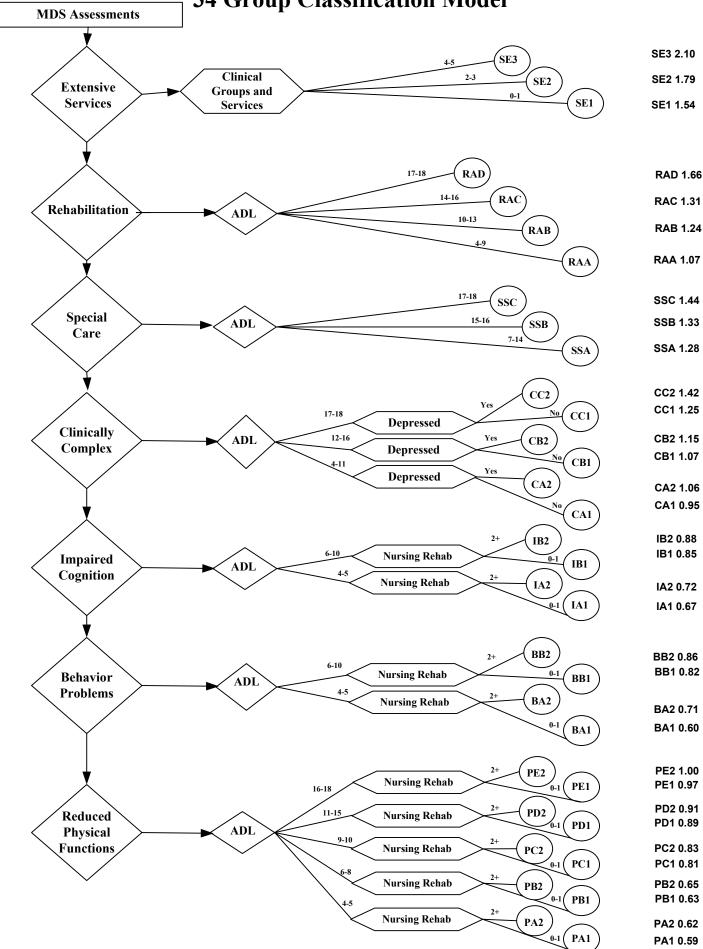
For example, if the assessment qualifies in one of the Extensive Services groups and also in the Rehabilitation group, always choose the Extensive Services classification, since it is higher in the RUG-III, 34-group hierarchy. Likewise, if the assessment qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearer the top of the model.

### **Index Maximizing Classification**

Index maximizing classification is used in many payment systems including Medicare and Medicaid. The first step in index maximizing is to determine all of the 34 individual RUG-III groups for which the assessment qualifies. Then, from the selected groups, pick the RUG-III classification with the highest Case Mix Index (CMI). In the resource utilization group systems, each category is assigned a weight. These weights represent the mean resource use of individuals within that group compared to the distribution of resident groups in the population. These weights or CMIs are used in the rate calculation to adjust for case mix.

For example, if the assessment qualifies in one of the Extensive Services groups and Rehabilitation group, choose the RUG-III classification with the higher CMI. Likewise, if the assessment qualifies for Special Care and Clinically Complex, again choose the RUG-III classification with the higher CMI. For index maximizing always pick the classification with the highest CMI.

# Louisiana RUG-III, Version 5.12 34 Group Classification Model



### Activities of Daily Living Calculation

The ADL Score calculation includes G1a (bed mobility), G1b (transfer), G1i (toilet use) and an eating calculation as described below:

**Step 1:** To calculate the score of G1a (Bed Mobility), G1b (Transfer), and G1i (Toilet Use), use the following chart. The eating ADL calculation will begin in Step #2. Place the transmitted values in the table below to determine the associated ADL Score for bed mobility, transfer and toilet use. Record the scores in the box in Step #3.

Column A =		Column B =	ADL Score
0 or 1	and	any number	= 1
2	and	any number	= 3
3, 4	and	0, 1 or 2	= 4
3, 4 3, 4 or 8	and	3 or 8	= 5

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	_//

### **Documentation Checkpoint**

<b>Documentation Checkpoin</b>
--------------------------------

Yes No Is ADL documentation complete, dated, signed and accurate?

G1a_	
G1b	
Gli	
G1h	

**Step 2:** a) To complete the Eating ADL Score calculation use the criteria below: (only apply one eating ADL Score when the assessment is coded for IV and tube feed)

K5a = checked	ADL Score = 3 OR
K5b = checked + K6a = 3  or  4	ADL Score = 3 OR
K5b = checked + K6a = 2 <b>AND</b> $K6b = 2, 3, 4, 5$	ADL Score = 3

STOP	<b>Documentation</b>	Ch a alem aime
Olor	<u>Documentation</u>	Cneckpoini

K5a = Parenteral/IV K5b = Feeding Tube K6a = Calories K6b = Fluid Intake

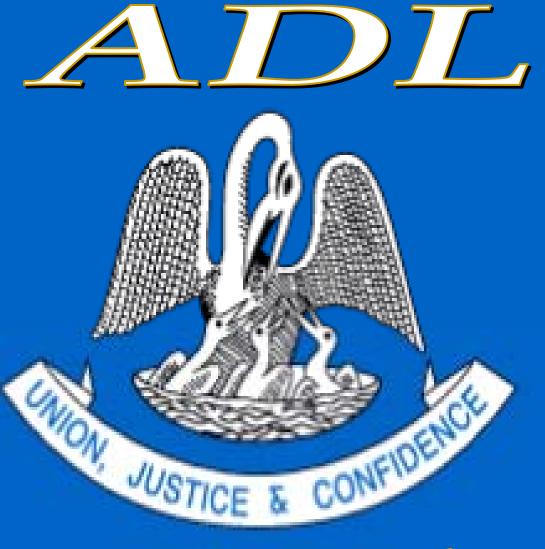
K5a	
K5b	
K6a	
K6b	

**b)** If no parenteral/IV or feeding tube is coded, return to G1hA to calculate the **eating** score using the chart below. Record the scores in the box in Step #3.

Column A =	ADL Score =
0 or 1	= 1
2	= 2
3, 4 or 8	= 3

**Step 3:** The total ADL Score range possibilities are 4 through 18 and include the ADL sum for G1a, G1b, G1i and the eating score. Total ADL Score:

Bed Mobility (G1a) =	
Transfer $(G1b) =$	
Toilet Use (G1i) =	
Eating =	
Total ADL =	



# Samples

					Sel	f-Per	forr	nance	e Ke	y					5	Supp	ort Provide	ed Key
1 = St 2 = Li m 3 = Ex *W *Ft 4 = To 8 = Ao	upervision mited A laneuver densive Veight-boall staff ot al Depotivity E lessonsible resident	on—O Assista ring of Assist earing perfor bender Did No bility out's AL	versight nce—R limbs tance-I support mance nceFul t Occur of the po DL self-p	or other including the staff person compared to the staff person compared	rageme: ighly in non-we perform rforma shift upleting nce oven	nvolved ight bear ned part nce of ac the docu	in activing assortivity of activity of act	ity; recei	elp of t tire shi elf-perf hours a	the follow ft formance a day – i.	wing ty is to ca e., not c	pe(s) we pture the	e total p		1 =S 2 =O 3 =T 8 =A The a docu the n recei	etup help one perso wo+ perso ctivity di responsib mentatio naximum	or physical help fro only n physical assist ons physical assis d not occur ility of the person n for support prov amount of support	t completing the ided is to code t the resident
	N=Nights D=Day E=Evenings																	
	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a																	
D	Date 9/15 9/16 9/17 9/18 9/19 9/20 9/21 Likely																	
Bed	Transmitted Re															Review Value		
				Int		Int		Int		Int		Int		Int		Int		
		N	4	FS	4	FS	4	FS	4	FS	4	BB	4	FS	4	ВВ		
	elf form	D	4	ES	4	ES	4	КО	4	КО	4	ES	4	ES	4	ES		
		E	4	КО	4	КО	4	КО	4	ко	4	BB	4	КО	4	BB	-	
		N	3		2		2		3		2		2		3			
Sup	port ⁄ided	D	3		3		2		3		2		2		2			
	14104	E	3		2		3		3		2		3		3			
Resid	lent Na	ame	AN	NIE AF	PLE			Med	lical F	Record 1	No	101				_	ADL Score =	ADL Score =
Int.		Si	gnature	<u> </u>	Int			Signatu	re		Int.		Si	gnature		In	i. S	ignature
FS Fred Skeleton, CNA ES Ed Skeleton, CNA BB Betty Bones, RN											$R\mathcal{N}$		K	Kelley Oston	ry, LPN			
	Ration	ıale:			•						•	•				•	-	

Example #1

		Self-Per	formance	e Key			Supp	ort Provided Key
0 =IndependentN 1 =Supervision — O 2 =Limited Assista maneuvering o 3 =Extensive Assis *Weight-bearing *Full staff perfo 4 =Total Dependent 8 =Activity Did No The responsibility of the resident's All evaluating clinicia	Oversight, encour nace—Resident h f limbs or other r stanceResident p g support rmance naceFull staff per ot Occur on this s of the person com DL self-performan	agement or cueing hear on the control of the contro	n activity; recei ing assistance of activity but h ivity during en mentation for so n day period, 24	elp of the follow tire shift elf-performance hours a day – i.	wing type(s) we  is to capture the e.e., not only how	e total picture	1 =Setup hely 2 =One perso 3 =Two+ perso 8 =Activity d The responsib documentation the maximum	n physical assist sons physical assist
		N=Nights	D=Day	E=Ever	nings			
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a	
Date	9/15/04	9/16/04	9/17/04	9/18/04	9/19/04	9/20/04	9/21/04	Likely

		Da	ay 1	D	ay 2	D	ay 3	D	ay 4	D	ay 5	Da	ay 6	A	\3a																																										
Date		9/1	5/04	9/1	16/04	9/	17/04	9/1	18/04	9/1	9/04	9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/20/04		9/2	21/04	Likely	
Trar	ısfers	- How	residen	t move			faces – to E to/froi	,		hair, w	heelcha	ir, stan	ding po	sition		Transmitted Value	Review Value																																								
			Int		Int		Int		Int		Int		Int		Int																																										
	N	8	FS	8	FS	8	FS	8	FS	8	ВВ	8	BB	8	ВВ																																										
Self Perform	D	2	TS	4	TS	2	ES	4	ES	2	ES	2	TS	2	TS																																										
1 01101111	E	2	TS	2	TS	2	ES	2	FS	2	ES	2	ES	2	ES																																										
	N	8		8		8		8		8		8		8																																											
Support Provided	D	2		3		2		3		2		2		2																																											
Tiovided	Е	2		2		2		2		2		2		2																																											

Resident Name Medical Record No. ADL Score = Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	BB	Betty Bones, RN	TS	Ted Skeleton, CNA	ES	Ed Skeleton, CNA

Rationale:

Example #2A

	Self-Performance Key  IndependentNo help or oversight 0														5	Support Provided Key			
1 = Suj 2 = Lin ma 3 = Ext *We *Ful 4 = Tot 8 = Act	pervision ited A ineuver sensive seight-be ill staff per ital Deptivity D sponsibresiden	on—O ssistar ing of Assist earing perfor enden id No rility of t's AD	oversight nce—Refilembs of lance—Refilembs of support mance nce—Full to Occur of the people of the p	at, encoura esident hi or other n desident p t d staff per on this sl	ngemen ghly in on-wei erform forman nift oleting ce over	volved ght bea ed part ce of a the doc the sev	I in active aring asset of active dectivity decumentary	rity; receisistance rity but had	tire shi	the follow ft formance a day – i.	wing ty  is to ca e., not c	pe(s) we pture th	e total į		1 =S: 2 = O 3 = T 8 = A The a docu the n recei	etup hone per wo+ potivity responsementa	elp or son person did i	physical help from nly physical assist as physical assist not occur by of the person co for support provide mount of support to a last seven days in	mpleting the ed is to code he resident
	valuating clinician sees the resident, but how the resident performs on other shifts as well.  N=Nights D=Day E=Evenings																		
	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a																		
Da	te		9/1	5/04	9/10	5/04	9/1	17/04	9/1	18/04	9/1	9/04	9/2	0/04	9/21/04			Likely	
	Tran	sfers	- How	resident	moves			faces – to E to/froi			hair, w	heelcha	ir, stan	ding po	sition			Transmitted Value	Review Value
				Int		Int		Int		Int		Int		Int		Int			
		N	8	FS	8	FS	8	FS	8	FS	8	BB	8	ВВ	8	BB			
Se Perfo		D	2	TS	4	TS	2	ES	4	ES	2	ES	2	TS	2	TS			
		E	2	TS	2	TS	2	ES	2	FS	2	ES	2	ES	2	ES			
		N	8		8		8		8		8		8		8				
Supp Provi	I	D	2		3		2		3		2		2		2				
11011		E	2		2		2		2		2		2		2				
Reside	ent Na	me						Med	dical I	Record 1	No	202				_		ADL core =	ADL Score =
Int.		Sig	gnature		Int.			Signatu	ire		Int.		Si	gnature			Int.	Sig	nature
FS Fred Skeleton, CNA BB Betty Bones, RN TS Ted Skeleton, CNA ES Es											Ed Skeleton, CNA								

Example #2B

Rationale:

				Self	f-Per	fori	nance	e Ke	e <b>y</b>					9	Supp	ort Provide	d Key	
0 =Independ 1 =Supervisi 2 =Limited A maneuve: 3 =Extensive *Weight-b *Full staff 4 =Total Dep 8 =Activity I  The responsit of the resident evaluating cl	on—C Assista ring of Assis earing perfor pender Did No bility of tr's AI	Oversigly nce—R f limbs tance—I g suppo rmance nce—Ful of Occur of the po DL self-j	nt, encour esident hi or other n Resident p rt I staff per c on this s	agemer ighly ir ion-wei perform formar hift pleting ice over	nvolved ight beared part nce of act the docathe several the several nce of the several nc	in activing as of activity of	vity; recei sistance vity but h during en tion for s period, 24	elp of t tire shi elf-perf hours	the follow ift formance a day – i.	wing ty  is to ca e., not c	rpe(s) we upture the only how	e total j		1 = S 2 = C 3 = T 8 = A The docu the 1 recei	etup hel One perso wo+ per octivity d responsil mentation naximum	or physical help from p only on physical assist sons physical assist id not occur  bility of the person co on for support provid a amount of support the last seven days i	ompleting the led is to code the resident	
				N=1	Nights	Ι	D=Day		E=Even	nings						_		
		D	ay 1	Da	ay 2	Г	Day 3	D	ay 4	D	ay 5	D	ay 6	A	A3a			
Date		9/1	5/04	9/1	6/04	9/	17/04	9/1	18/04	9/1	9/04	9/2	20/04	9/2	21/04	Likely		
	trar		et Use – n/off toi						`		1	,				Transmitted Value	Review Value	
			Int		Int		Int		Int		Int		Int		Int			
	N	4	FS	4	FS	4	FS	4	FS	4	ES	4	ES	4	ES			
Self Perform	D	4	ES	3	ES	4	ES	4	RS	4	RS	4	RS	4	RS			
1 01101111	Е	4	ES	4	TS	4	TS	4	RS	4	RS	4	TS	4	TS	1		
	N	3		3		3		3		3		3		3				
Support	D	3		3		3		3		3		3		3				
Provided	E	3		3		3		3		3		3		3				
Resident N	ame	l	UE BER	RY	Medical Record No. 303											ADL Score =	ADL Score =	
Int.	Si	gnature	:	Int			Signatu	re		Int.		Si	gnature	Int. Signature				

FS Fred Skeleton, CNA ES Ed Skeleton, CNA TS Ted Skeleton, CNA	RS	Red Skeleton, CNA

Rationale:

				Sel	f-Per	forn	nance	e Ke	y						Supp	ort P	rovide	d Key
0 =Independ 1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b *Full staff	on—O Assistating of Assistating earing	versigh nce – Re limbs o tanceRe suppor	et, encour esident h or other i desident	ragemen ighly in non-we	nvolved i ight bear	in activ	ity; recei sistance	-	•	. 0		re prov	ided	1 = S 2 = O 3 = T	etup hel <sub>l</sub> ne perso	p only on physi sons phy	cal help from cal assist ysical assist ccur	ı staff
4 =Total Dep 8 =Activity I The responsit of the residen evaluating cl	Did No bility o ıt's AL	ot Occur of the pe OL self-p	on this s erson com performan	shift ipleting ice over	the docu the seve	menta n day p	tion for so	elf-perf hours a	ormance 1 day – i.	e., not d	only how		oicture	docu the n recei	mentatio naximum	on for su amoun	the person co pport provide t of support t seven days in	ed is to code
				N=	Nights	Γ	D=Day		E=Ever	nings								
		Da	ay 1	D	ay 2	D	ay 3	D	ay 4	Da	ay 5	Da	ay 6	A	<b>13a</b>			
Date		9/1	5/04	9/1	16/04	9/1	17/04	9/1	.8/04	9/1	9/04	9/2	0/04	9/2	21/04		Likely	
	tran						he toilet : s pad, m		`		-	,				Tr	ransmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int			
	N	4	FS T	54	FS	4	FS	4	FS	4	ES	4	ES	4	ES			
Self Perform	D	4	E <b>S)</b> [3	734	ES	4	ES	4	RS	4	RS	4	RS	4	RS			
_ *********	E	4	ES	4	TS	4	TS	4	RS	4	RS	4	TS	4	TS			
_	N	3		3		3		3		3		3		3		_		
Support Provided	D	3		3		3		3		3		3		3				
i iuviueu																		

**Resident Name** 

**BLUE BERRY** 

3

Medical Record No. 303

ADL Score = ADL Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ES	Ed Skeleton, CNA	TS	Ted Skeleton, CNA	RS	Red Skeleton, CNA

3

Rationale:

Example #3B

				Sel	f-Per	forr	nance	e Ke	V					5	Supp	ort	Provided	Kev
0 =Independ 1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b *Full staff 4 =Total Dep 8 =Activity I The responsi- of the resider evaluating ci	Assista ring of Assis Assis earing perfor pender Did No bility of bility of	Oversight nce—Ref limbs of limbs of the people of the peop	at, encour esident h or other i Resident j t I staff per on this s	ght ageme ighly in non-we perform rforma shift upleting	nt or cue nvolved i ight bear ned part nce of act	ing proin activing assortions activity dementa	ovided vity; receivisistance vity but h luring ention for se	ved ph elp of t tire shi elf-perf hours a	ysical he the follow ft formance a day - i.	ving ty  is to ca e., not c	pe(s) we pture the only how	e total p		0 =N 1 =So 2 =O 3 =T 8 =A The 1 docu the n recei	o setup of the person wo person wo person ctivity dispersion of the person sibustical mentation aximum	or phy o only n phy sons j id no wility on for	ysical help from st y ysical assist physical assist	taff  pleting the is to code resident
				N=	Nights	Γ	D=Day		E=Even	ings						_		
		Da	ay 1	D	ay 2	D	ay 3	D	ay 4	Da	ay 5	Da	ny 6	A	.3a			
Date		9/1	5/04	9/1	16/04	9/:	17/04	9/2	20/04	9/2	1/04	9/2	2/05	9/2	4/04		Likely	
Trar	ısfers	- How	residen	t move			faces – to E to/fror			nair, w	heelcha	ir, stan	ding po	sition			Transmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int			
	N	4	FS	4	FS	4	FS	2	ВВ	2	BB	3	BB	2	BB			
Self Perform	D	4	СО	4	CO	4	СО	1	СО	2	CO	3	BB	1	CO			

			Int												
	N	4	FS	4	FS	4	FS	2	ВВ	2	ВВ	3	ВВ	2	BB
Self Perform	D	4	СО	4	CO	4	CO	1	СО	2	СО	3	ВВ	1	CO
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS
	N	3		3		3		2		2		3		2	
Support Provided	D	3		3		3		1		2		3		1	
Tioviaca	E	3		3		3		2		2		3		1	

ADL ADL Medical Record No. 404 Score = Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ВВ	Betty Bones, RN	CO	Cole Ostomy, LPN	TS	Ted Skeleton, CNA

1110.	Signature	1110.	5161tatare	1116.	Signature	1110.	Signature
FS	Fred Skeleton, CNA	BB	Betty Bones, RN	СО	Cole Ostomy, LPN	TS	Ted Skeleton, CNA

Rationale:

		Self-Per	formance	Key				5	Supp	ort Provided	Key
1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b	dentNo help or ove ion – Oversight, enc Assistance – Resider ering of limbs or oth e AssistanceReside bearing support	ouragement or cue it highly involved er non-weight bear	in activity; receiv		- 0		ere provided	1 = Se 2 = O 3 = T	etup help ne perso wo+ pers	or physical help from so o only n physical assist sons physical assist id not occur	staff
4 =Total Dep 8 =Activity l The responsi of the resider	f performance pendenceFull staff Did Not Occur on th ibility of the person of the self-perforn linician sees the resi	is shift completing the docu nance over the seve	mentation for se n day period, 24	lf-performan hours a day -	i.e., not	only hou		docu the n	nentatio aximum ved over	wility of the person com on for support provided amount of support the the last seven days irre	is to code resident
		N=Nights	D=Day	E=Ev	enings					-	
	Day 1	Day 2	Day 3	Day 4	D	ay 5	Day 6	A	.3a		
Date	9/15/04	9/16/04	9/17/04	9/20/04	9/2	21/04	9/22/05	9/2	4/04	Likely	
Trai	nsfers - How resid		en surfaces – to CLUDE to/fron	•		vheelcha	ir, standing po	sition		Transmitted Value	Review Value
	Int	Int	Int	Int		Int	Int		Int		
	N 4 FS	4 FS	4 FS	2 BB	2	BB	3 BB /	2	BB		
Self Perform	D 4/ CX	4/	4/ 00	1 CC	2	СО	3 BB	1	CO		
1 61101111	E 4 TS	TS	W TS	2 TS	2	FS	3 FS	1	FS		

Resident Na	ame	CU	E CUM	BER		Med	dical R	lecord :	No	404			_	ADL Score =	ADL Score =
11011464	Е	3	/	3	3		2		2		3	1			
Support Provided	D	3		3	3		1		2		3	1			

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ВВ	Betty Bones, RN	CO	Cole Ostomy, LPN	TS	Ted Skeleton, CNA

Rationale:

Example #4A

				Sel	f-Per	forn	nance	e Ke	y					5	Supp	ort Provided	Key
0 =Independ 1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b	ion — C Assista ering of Assis earing	Oversight nce — Reference — Re	nt, encour esident h or other r Resident	ageme ighly in non-we	nvolved i ight bear	in activ	ity; recei sistance	-	-	- 0		re prov	ided	1 = S 2 = O 3 = T	etup helj ne perso wo+ pers	or physical help from s p only on physical assist sons physical assist id not occur	taff
4 =Total Dep 8 =Activity l  The responsi of the resider	Dependence—Full staff performance of activity during entire shift ity Did Not Occur on this shift  onsibility of the person completing the documentation for self-performance is to capture the total picture sident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the ng clinician sees the resident, but how the resident performs on other shifts as well.  N=Nights D=Day E=Evenings													The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.			
				N=	Nights	Γ	D=Day		E=Ever	ings							
		D	ay 1	D	ay 2	D	ay 3	D	ay 4	D	ay 5	Da	ay 6	A	.3a		
Date		9/1	.5/04	9/1	16/04	9/:	17/04	9/2	20/04	9/2	21/04	9/2	2/05	9/2	4/04	Likely	
Trai	nsfers	- How	residen	t move			faces – to E to/froi			hair, w	heelcha	ir, stan	ding po	sition		Transmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int		
	N	4	FS	4	FS	4	FS	2	ВВ	2	ВВ	3	BB	2	BB		
Self Perform	D	4	СО	4	CO	4	CO	1	СО	2	СО	3	BB	1	СО		
	E	4	TS	4	TS	4	TS	2	TS	2	FS	3	FS	1	FS		
	N	3		3		3		2		2		3		2			
Support	D	2		2		2		1		2		2		1			

Resident Name	CUE CUMBER	Medical Record No.	404	$\mathbf{ADL}$	$\mathbf{ADL}$
Resident Name	CUE CONIDER	Wiedicai Record No.	404	Score =	Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	BB	Betty Bones, RN	CO	Cole Ostomy, LPN	TS	Ted Skeleton, CNA

Rationale:

Provided

D

E

Example #4B

				Sel	f-Per	forr	nance	Ke	<b>y</b>					5	Supp	or	t Provided	Key
3 =Extensive *Weight-b	ion — C Assista ering of Assis bearing	Oversigl nce – R f limbs tancel s suppo	nt, encour esident h or other r Resident 1	ageme ighly i ion-we	nvolved i eight bear	n activ	vity; receiv sistance	-	•			re prov	ided	1 = So 2 = O 3 = T	etup help ne perso	p on on p sons	hysical assist s physical assist	taff
*Full staff 4 =Total Dep 8 =Activity l  The responsi of the resider evaluating c	pender Did No ibility o nt's AL	nceFul of Occur of the po OL self- <sub>1</sub>	r on this s erson com verforman	hift pleting ce ove	g the docu r the seve	menta n day p	victure	docu the n recei	mentatio naximum	on fo i am	y of the person compor support provided to support the last seven days irre	is to code resident						
				N=	Nights	Ι	D=Day		E=Ever	ings			pР	,				
		P	ay 1	Q	ay 2	Ď	ay 3	D	ay 4	D	ay 5	Da	ay 69/22	104 A	.3a			
Date		9/1	15/04	9/:	16/04	21	17/04	9/2	20/04	9/2	21/04	9/22/	/05 04	9/2	4/04		Likely	
Trai	nsfers	- How	resident	move			faces – to E to/fron			hair, w	heelcha	ir, stan	ding po	sition			Transmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int			
6.14	N	4	FS	4	FS	4	FS /	2	BB	2	ВВ	3	BB	2	BB			
Self Perform	D	4	Ø	$\sqrt{4}$	CXX	$\sqrt{4}$	CX	1	CO	2	CO	3	ВВ	1	CO			
	E	4	TS	₩	TS	<b>W</b>	ΓS	2	TS	2	FS	3	FS	1	FS			
				Λ		٨												

_	J		ŭ	\	 \			_		Ŭ	_			
Resident Name	CII	E CLIM	RFR		Mod	lical R	ecord 1	No	404				$\mathbf{ADL}$	$\mathbf{ADL}$
Resident Name		L CUNI	DLK		 Med	iicai N	ecoru		404			_	Score =	Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ВВ	Betty Bones, RN	CO	Cole Ostomy, LPN	TS	Ted Skeleton, CNA

Rationale:

Support Provided

Example #4B

### (Observation Period 9/15 - 9/21/04)

Self-Performance Key	Support Provided Key
0 =IndependentNo help or oversight	0 =No setup or physical help from staff
1 =Supervision – Oversight, encouragement or cueing provided	1 =Setup help only
2 = Limited Assistance – Resident highly involved in activity; received physical help in guided	2 =One person physical assist
maneuvering of limbs or other non-weight bearing assistance	3 =Two+ persons physical assist
3 =Extensive AssistanceResident performed part of activity but help of the following type(s) were provided	8 =Activity did not occur
*Weight-bearing support	
*Full staff performance	
4 =Total DependenceFull staff performance of activity during entire shift	
8 =Activity Did Not Occur on this shift	The responsibility of the person completing the documentation for support provided is to code
The responsibility of the person completing the documentation for self-performance is to capture the total picture	the maximum amount of support the resident
of the resident's ADL self-performance over the seven day period, 24 hours a day - i.e., not only how the	received over the last seven days irrespective of
evaluating clinician sees the resident, but how the resident performs on other shifts as well.	frequency.

		N=Nights	D=Day	E=Even	ings		_
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a
Date							
			1 1 :	1 / 11	C 1 111)		

**Eating-**How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (tube feeding, total parenteral nutrition.

			Int												
	N	1	FS	1	FS	2	FS	1	RS	2	RS	1	RS	1	RS
Self Perform	D	0	ES	0	ES	0	ES	0	TS	0	RS	0	ES	0	ES
	E	1	ES	1	TS	1	TS	1	TS	1	TS	0	TS	1	TS

Likely Transmitted Value

Review Value

Resident Name CANDY APPLE Medical Record No. 505 ADL Score = Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ES	Ed Skeleton, CNA	TS	Ted Skeleton, CNA	RS	Red Skeleton, CNA

Rationale:

Example #5

Rationate.			

### Definition of (1) Supervision

Oversight, encouragement or cueing provided 3 or more times during last 7 days

### <u>OR</u>

Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

					Sel	f-Per	forr	nanc	e Ke	e <b>y</b>					S	Supp	ort	Provi	ded	Key
1 =Su 2 =Lin m 3 =Ex *W	pervision in the desired A aneuver tensive	on — O Assistar ring of Assist earing	oversight nce — Re limbs o tanceRe support	sident hi or other r esident p	ageme ighly i non-we	nt or cue nvolved eight bea ned part	in activ	vity; rece sistance	-		- 0		ere prov	ided	1 = Se 2 = O: 3 = Tr	etup he ne pers wo+ pe	lp onl son ph rsons	ysical help y ysical assic physical as t occur	st	taff
8 = Ac	etivity D esponsil e residen	Did No bility c it's AD	ot Occur of the per OL self-pe	on this s rson com erforman	hift pleting ice over	nce of ac g the doci r the seve now the re	umenta en day p	tion for s	self-perj 4 hours	formance a day - i	.e., not c	nly hou		victure	docur the m	mentat iaximu ved ove	ion for m amo	support prount of supp	rovided port the	
						Nights		D=Day		E=Eve	T						-			
				y 1	D	ay 2	D	Day 3	D	Pay 4	Da	ay 5	D	ay 6	A	.3a				
<i>D</i>	ate		Toile	5/04 et Use -		resident				`		-	,		<u> </u>		1	Likely Transmitt Value	ted	Review
		tran	sfers on	n/off toi	let, cle	eanses, c	hange	s pad, n	nanage	s ostom	y or cat	heter, a	djusts	clothes.				varue		Value
		tran	sfers on	n/off toi Int	let, cle	eanses, c	hange	s pad, n Int	nanage	s ostom	y or cat	heter, a Int	djusts (	lothes.  Int		Int	┨-	vaiue		Value
	elf Form	tran N D	sfers or		H		hange	_	nanage		y or cat		djusts			Int	-   	varue		Value
	elf Form	N	$\times$	Int	H		hange	_	nanage		y or cat		djusts (			Int	- - - -	varue		Value
Perf	orm	N D	$\times$	Int	H O S		hange	_	nanage		y or cat		djusts			Int	- - - -	varue		Value
Perf	orm	N D E	$\times$	Int	H O S P		hange	_	nanage		y or cat		djusts (			Int	- -	varue	_	Value
Perf Supp Prov	orm	N D E N D E	3	Int	H O S P T A L	Int	hange	Int				Int	djusts (			Int		DL ore =		ADL Score =
Perf Supp Prov	port rided	N D E N D E ame	3	Int BB	H O S P T A L	Int	hange	Int	dical	Int		Int						DL	Signa	ADL Score =

### **EXAMPLE #6A**

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

				(	Self	-Perf	forn	nance	Ke	y					9	Supp	ort	t Provide	d Key
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Da	te		9/15/	04														Likely	
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Reside	ent Na	ame	OLLI	E ORA	NGE			Med	lical F	Record	No	606				_		DL ore =	ADL Score =
Int.		Si	gnature		Int.			Signatu	re		Int.		Si	gnature		I	nt.	Si	gnature
ВВ	Betty	Bone	es, RN																
Ratio	onale	:				1					1								

Example #6A

### **EXAMPLE #6A**

**Definition of (0) Independent No help or oversight** 

OR

Help/Oversight provided only 1 or 2 times during last 7 days. If the activity occurred less than three times in the look back period, code "0" Independent, regardless of level of assistance required.

				Se	lf-Per	for	manc	e Ke	ey					S	Supp	ort	Provide	d Key
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The re of the	esponsil residen	bility o ıt's AL	ot Occur on this of the person co DL self-perform n sees the resid	mpletii ance ov	er the seve	en day	period, 24	hours	a day - i	.e., not	only hou		nicture	docun the m	mentati iaximun ved ovei	on for . 1 amoi	of the person consupport provident of support street seven days	ded is to code
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D			Day 1	]	Day 2	1	Day 3	L	Day 4	D	ay 5	D	ay 6	A	.3a			
Da Bed		lity – l	9/15/04 How resident	moves	to and fr	om ly	ing posit	ion, tu	ırns side	to side	e, and p	l osition	s body v	l while in	bed.		Likely Transmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int			
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Supp Provi		N D E	3	I T A L												-		
Resid	ent N	ame	OLLIE O	RANC	GE		Med	dical 1	Record	No.	606				_	AI Scor		ADL Score =
Int.		Si	gnature	I	nt.		Signatu	ıre		Int.		Si	gnature		Iı	ıt.	Si	gnature
ВВ	Bett	у Вопе	es, RN															
Rat	tiona	le: _																

Example #6B1 \*See nurse's note 9/15/04

## **EXAMPLE #6B (1)**

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

				Self	-Per	forr	nance	e Ke	e <b>y</b>					5	Supp	ort Pro	ovide	d Key
1 = Su 2 = Li: m 3 = Ex *W *Fu 4 = To 8 = Ao	pervision mited A aneuver tensive eight-beall staff otal Depetivity Descriptions of the control	on—Cassistaring of Assistaring of Assistaring performance of Did Notice of the Control of the Control of the Control of Assistant of the Control of the Cont	No help or oversig Oversight, encour- ince—Resident his f limbs or other natance—Resident part g support rmance ince—Full staff per of Occur on this so of the person components	agementighly inviton-weigoerforment	volved i ght bear ed part o ce of act	n activing assort activity of activity of menta	vity; receisistance vity but he during entition for so	elp of tire shi	the follo	wing ty	pe(s) we	e total į		1 = So 2 = O 3 = To 8 = A The r documents	etup hely ne perso wo+ perso ctivity d responsib mentation naximum	n physical sons physi id not occu wility of the on for supp amount oj	assist cal assist ur  person correct provide full support	ompleting the ded is to code the resident irrespective of
evalu	ating cl	inicia	n sees the resident					on oth			•			frequ	епсу.			
			Day 1	Da	Vights		D=Day Day 3	D	E=Ever		ay 5	D	ay 6	A	.3a			
Da	ate		9/15/04		<i>y</i>		<u> </u>				<u> </u>		<u> </u>			Li	kelv	
Bed	Mobil	ity -	How resident m	oves to	and fro	om lyi	ing posit	ion, tu	rns side	to side	e, and p	osition	s body v	vhile ir	n bed.		smitted alue	Review Value
			Int		Int		Int		Int		Int		Int		Int			
	elf Form	N D E	3* BB	H O S P														
Sup <sub>]</sub> Prov	-	N D E	3	I T A L														
Resid	ent Na	ame	OLLIE OR.	ANGE			Med	lical I	Record	No.	606				_	ADL Score =		ADL Score =
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ВВ	Betty	Bon.	es, RN															
Ra	tiona	le:																

Example #6B1 \*See nurse's note 9/15/04

					Self	-Per	forr	nanc	e Ke	y					S	Supp	ort	Provide	d Key
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of the	N=Nights D=Day E=Evenings															the resident			
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Da	Date 9/15/04 Likely																		
	Likely																		
			Ι	[nt		Int		Int		Int		Int		Int		Int			
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Resid	ent Na	ame	OLLI	E ORA	NGE			Med	dical F	Record	No	606				_		DL ore =	ADL Score =
Int.		Si	gnature		Int.			Signatu	ıre		Int.		Si	gnature		Iı	nt.	Si	gnature
ВВ	Betty	y Bon	es, RN																
Ra	tiona	le:												<u> </u>					

\*See nurse's note 9/15/04

## **EXAMPLE #6B (2)**

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

					Sel	f-Per	forn	nanc	e Ke	<b>y</b>					9	Supp	or	t Provi	ded	Key
1 =Sup 2 =Lim mar 3 =Exte *Wei	ervisi ited A neuve ensive ight-b	on—C Assista ring of Assist earing	versigh nce – Re f limbs (	or oversig it, encour esident h or other r Lesident j t	agemen ighly in non-we	nvolved i ight bear	in activ	ity; recei sistance	-	•			re prov	ided	1 = So 2 = O 3 = T	etup hel ne pers wo+ per	lp on on pl rsons	nysical help ly nysical assis physical ass ot occur	t	staff
4 =Tota	al Dep	ender	ceFul	l staff per on this s		nce of ac	tivity d	luring en	itire shi	ft								of the person r support pro		
of the r	The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.  N=Nights D=Day E=Evenings  Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a																			
					N=	Nights	Г	D=Day		E=Ever	ings									
	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a																			
Date	Date 9/15/04 Likely																			
	Date 9/15/04 Likely Transfers - How resident moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)  Review Value																			
				Int		Int		Int		Int		Int		Int		Int				
Self	f	N	$\times$	$\times$	H												4			
Perfo		D	3*	BB	S				<u> </u>											
		E	$\stackrel{\sim}{\longleftrightarrow}$	$\times$	P														_	
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Provid		D	3		A															
		E	$\times$		L													DI		ADI
Reside	nt N	ame	OLI	LIE OR	ANG	E		Med	dical I	Record	No	606				_		DL ore =	:	ADL Score =
Int.		Si	gnature		Int	·•		Signatu	ıre		Int.		Si	gnature		I	nt.		Sign	ature
ВВ	Bett	у Вопе	es, RN																	
Rati	iona	le:																		
Exampl	e #6	Б2	*See	nurse's	s note	9/15/04	4													

					Self	-Per	forn	nance	Ke	<b>y</b>					5	Supp	or	t Provide	d Key
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			Da	y 1	Da	y 2	D	ay 3	D	ay 4	Da	ıy 5	Da	ay 6	A	.3a			
Da	ate		9/15	<i>'</i>														Likely	
		Inc	cludes i	<b>Eat</b> intake of 1	_			ats and d er means		` _		,	ral nut	rition.				Transmitted Value	Review Value
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Se Perf		N D	1*	BB	H O S P I T A L														ADL
	ent Na			IE ORA						Record		606				-	Sco	ore =	Score =
Int. BB	<i>(</i> ) -4.1		gnature		Int.			Signatu	re		Int.		Si	gnature		11	nt.	Sig	gnature
עט	Betty	у Бопе	es, RN																
Ra	tional	le:																	

## **EXAMPLE #6B (3)**

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

					Sel	f-Per	forn	nance	e Ke	y					9	Supp	or	t Provide	d Key
1 =St 2 =Li m 3 =Ex *W	ipervisi mited A aneuve tensive	on – O Assistar ring of Assist earing	o help or oversight, once—Residimbs or of ance-Residimport	encoura dent his other n	ngemen ghly ir on-wei	ivolved i	n activ	ity; recei <sup>.</sup> istance	-	-			ere prov	ided	1 = S 2 = O 3 = T	etup he Ine pers wo+ pe	lp on on pl rsons	hysical help from lly hysical assist s physical assist not occur	n staff
4 =T	otal Dep	enden	ceFull st t Occur or			nce of act	ivity d	uring en	tire shi	ft					docu	mentat	ion fo	y of the person co or support provid	ed is to code
of the	the responsibility of the person completing the documentation for self-performance is to capture the total picture the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the aluating clinician sees the resident, but how the resident performs on other shifts as well.  N=Nights  D=Day  E=Evenings  Day 1  Day 2  Day 3  Day 4  Day 5  Day 6  A3a																		
	N=Nights D=Day E=Evenings  Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a  Date																		
	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a																		
D	Date 9/15/04 Likely																		
	Date 9/15/04 Likely  Eating-How resident eats and drinks (regardless of skill).  Includes intake of nourishment by other means (tube feeding, total parenteral nutrition.  Likely  Transmitted  Value  Review  Value																		
			]	Int		Int		Int		Int		Int		Int		Int			
		N	$\times$	X	H O														
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R.	tiona		· -		1														
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'yamı	ale #6	R3 —																	

					Sel	f-Per	forı	nance	Ke	y					5	Supp	ort	Provide	d Key
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		trar						the toilet s pad, m		`		-	,				ľ	Transmitted Value	Review Value
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Supp Provi		N D E	3		I T A L												-		
Reside	ent Na	ame	OLI	LIE OR	ANG	E		Med	lical I	Record	No.	606				_	AE Scor		ADL Score =
Int.		Si	ignature		Int			Signatu	re		Int.		Si	gnature		Ir	ıt.	Si	gnature
ВВ	Betty	y Bon	es, RN																
Rat	tiona	la:			-	-					_								

## **EXAMPLE #6B (4)**

9/15/04 10:00 am. Admitted Mrs. Orange from hospital following right hip ORIF. Alert, oriented. Staples intact. Surgical wound clean, no redness or drainage. Requires extensive assist with ADLs. Able to feed self breakfast.

9/15/04 11:30 am. Required extensive assist of one for transfer from bed to wheelchair, extensive assist of one for toilet use one time this morning. Able to feed self AM snack. Staff propels wheelchair.

9/15/04 2:00 pm. Required extensive assist of two for toileting; extensive assist of two for transfers and bed mobility. Unable to stand and transfer alone. Unable to turn and reposition self in bed. Needed help managing clothing and transferring on and off toilet.

9/15/04 7:00 pm. Extensive assist of two for toileting; tired, complaining of pain to right hip. Fed self at supper with encouragement. Appetite fair. Extensive assist of two for transfer from chair to bed.

9/15/04 8:00 pm. Complaining of shortness of breath. Diaphoretic. Appears to be in acute distress. MD notified, and order received to send to ER for evaluation.

					Sel	t-Per	tori	mance	e Ke	y					5	supp	ort P	rovide	d Key
1 =Supe 2 =Limi man 3 =Exte *Wei *Full 4 =Tota 8 =Activ	ervision ited Aneuvensive ght-boat staff al Depvity E	on—Cassista ring of Assis earing perfor bender Did No bility of bility of	oversight nce—Ref I limbs of tance—Ref support mance nceFull of Occur of the people of DL self-p	or other n Resident p ct I staff per on this si erson comp performan	ageme ighly i ion-we perform forma hift pleting ce ove	nvolved eight beat ned part nee of act the doct of the sever the sever needs not the sever the sever the sever the sever the sever the sever needs nee	in actiring as of activity of	vity; recei	nelp of atire shi	the follo ift formance a day – i	wing ty	pe(s) we pture th only how	e total į		1 = So 2 = O 3 = Tr 8 = A The r docu the n receiv	etup hel one perso wo+ per ctivity d responsil mentatio naximun	p only on physic sons phy id not oc  pility of t on for sup	sical assist cur he person c port provi of support	ompleting the led is to code the resident irrespective of
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			Dá	ay 1	D	ay 2	I	Day 3	D	ay 4	Da	ay 5	Da	ay 6	A	\3a			
Date	Date 9/15/04 Likely																		
	Toilet Use – How resident uses the toilet room (commode, bedpan or urinal);  transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.  Transmitted Value  Value																		
				Int		Int		Int		Int		Int		Int		Int			
Self	f	N	$\times$	$\times$	H			—											
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ВВ	Betty	y Bone	es, RN	_															
Rati	iona	le: _				1					•	•				'	'		
xample	e #61	B4 -	4.0			0 11 = 10													

\*See nurse's note 9/15/04

9/15/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good. No weight loss. Needs limited assist with ADLs. No new problems.

### **EXAMPLE #7, continued**

#### Transmitted values for ADLs:

G1 A B

a.	Bed Mobility	How resident moves to and from lying position, turns side to side, and positions body while in bed	2	2
b.	Transfer	How resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	2	2
i.	Toilet Use	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	2	2
h.	Eating	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	2	2

#### ADL Score:

GIa) Bed Mobility	2 – 2	= 3
(G1b) Transfer	2 – 2	= 3

(G1i) Toilet Use 
$$2-2=3$$

(G1h) Eating 
$$2 = 2$$

#### Total ADL Score = 11

	Revieu	ved values for ADLs:		
a.	Bed Mobility		0	0
b.	Transfers		0	0
i.	Toilet Use		0	0
h.	Eating		0	0

#### Reviewed ADL Score:

<b>Total ADL Score</b>		= 4
(G1h) Eating	0	= 1
(G1i) Toilet Use	0 - 0	= 1
(G1b) Transfer	0 - 0	= 1
(G1a) Bed Mobility	0 - 0	= 1

9/15/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good. No weight loss. Needs limited assist with ADLs. No new problems.

NOTE: While this note explains why the MDS is coded limited assist for ADLs, it is not sufficient to support limited assist for the case mix review.

					Se	lf-Pe	rfor	manc	e K	ey						Su	pp	ort Provi	ded Key	
1 = 5 2 = I 3 = H *V *I 4 = T 8 = A	Supervision imited A maneuver Extensive Weight-befull staff Total Dep Activity Extensible responsible resident's	on—O assista- ring of Assist earing perfor bender Did No bility of ADL	oversight nce—Ro f limbs tance—F support mance nce—Full of Occur of the perself-per	I staff per on this s	ageme ighly in on-we perform format hift  pleting over th	nvolved right bear ned part nce of ac	in active ring associated of active tivity of the tivity o	vity; receisistance vity but huring en tion for so	elp of t tire shi elf-perf ours a d	the follow ft formance lay – i.e.,	wing ty	rpe(s) we	e total į	victure oj	1 2 3 8 8 The definition of th	=Setup =One p =Two+ =Activit he respo ocument aximum	help erson person ty did usibil nsibil ation	a physical assist ons physical assi I not occur lity of the person of for support pro	ist n completing the vided is to code he resident recei	the ved
	Over the last seven days irrespective of frequency  N=Nights D=Day E=Evenings  Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a  Likely																			
	Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a Likely															Likely				
Ι	Date																	Transmitted Value	Review Value	
		tran		<b>et Use –</b> n/off toi						`		-	,				-		_	_
				Int		Int		Int		Int		Int		Int		Int	]			
	Self	N	1	CS	1	AF	1	PN	1	CS	1	КО	1	CS	1	AF	_			
	rform	D	1	CS	1	КО	*3	KO	1	PN	1	PN	1	PN	1	КО	_			
		E	1	KO	1	PN	1	AF	1	CS	1	AF	1	KO	1	AF				
C	pport	N	0		0		0		0		0		0		0					
_	vided	D	0		0		*2		0		0		0		0					
		E	0		0		0		0		0		0		0			ADL	ADL	
Resi	dent Na	ame	BET	TY BAI	NAN	4		Med	ical R	ecord N	No	802					S	core =	Score =	
Int.		Sig	nature		Int			Signatu	re		Int.		Si	gnature		I	nt.	Si	gnature	
CS	Cinderel	la Smit	h, LPN		KC	) Kell	ey Oston	ny, LPN			AF	Andy	Flu, LP	<b>V</b>		F	'N	Patty Nurse, LA	en e	

Example # 8 Rationale:

### *Day 3 (7 - 3 Shift)*

Received PRN Lasix due to increased edema of feet and ankles. Resident unable to get to the bathroom in time and had four incontinent episodes on this shift. Required extensive assistance for cleansing and changing incontinent pads and clothing after each incontinent episode.

					Se	lf-Pe	erfoi	rman	ce K	ey						Sup	port P	rovi	ded Key
1 =Su 2 =Lir ma 3 =Ext *We	ipervis mited aneuv tensiv eight-	sion – Assist ering e Assi bearin	Oversig ance – F of limbs	or other Resident ort	ragem highly non-w	involve eight be	d in act	rovided ivity; reconssistance tivity but		-	-	o .	vere pro	vided	1 2 3	=Setup h =One pei =Two+ p	p or physica elp only rson physica ersons physi did not occu	l assist ical assi	
4 =Too 8 =Ac	otal De ctivity espons creside	epende Did N sibility ent's A	enceFu lot Occu of the p DL self-	ill staff p ir on this person cor performa	shift mpletin ince ov	ig the do er the se sident pe	cument ven day rforms		self-pe 24 hours shifts a	rformanc s a day – s well.	i.e., no	t only ho	the total	picture valuatinș	do g m	ocumenta aximum (	tion for supp amount of su	ort pro pport tl	n completing the wided is to code the he resident received ctive of frequency.
	Over the last seven days irrespective of frequency.  N=Nights D=Day E=Evenings  Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 A3a  Likely																		
	Day 1         Day 2         Day 3         Day 4         Day 5         Day 6         A3a         Likely           Date         9/15/04         9/16/04         9/17/04         9/18/04         9/19/04         9/20/04         9/21/04         Transmitted         Review															Daviary			
Date	e			-			<u> </u>	17/04 he toilet				-		<u> </u>	9/2	21/04	Valı		Value
		tran						s pad, m											
				Int		Int		Int		Int		Int		Int		Int			
Self	c	N	1	CS	1	AF	1	PN	1	CS	1	КО	1	CS	1	AF			
Perfo		D	1	CS	1	КО	*3	КО	1	PN	1	PN	1	PN	1	КО			
		E	1	KO	1	PN	1	AF	1	CS	1	AF	1	KO	1	AF			
Suppo	ort	N	0		0		0		0		0		0		0				
Provid		D	0		0		*2		0		0		0		0				
		E	0		0		0		0		0		0		0		ADL		ADL
Reside	nt Na	ame	BET	TY BA	NANA	<b>A</b>		Med	ical R	ecord N	No	802					Score =		Score =
Int.		Sig	nature		Int			Signatu	ıre		Int.		Si	gnature		In	t.	Sig	gnature
CS C	inderel	la Smi	th, LPN		KC	Kell	ey Oston	ny, LPN			AF	Andy	Flu, LPI	٧		PN	N Patty N	urse, LP	<b></b>
Ехатр	ole#	8	Ratio	nale:															

\*See nurse's note 9/17/04

				Sel	f-Per	forn	nanc	e Ke	y					S	uppo	ort P	rovid	led	Key
1 =Supervisi 2 =Limited A maneuver 3 =Extensive *Weight-b	=Independent—No help or oversight =Supervision — Oversight, encouragement or cueing provided =Limited Assistance — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance =Extensive Assistance—Resident performed part of activity but help of the following type(s) were provided *Weight-bearing support *Full staff performance =Total Dependence—Full staff performance of activity during entire shift																		
8 =Activity I  The responsit  of the residen	=Total DependenceFull staff performance of activity during entire shift =Activity Did Not Occur on this shift  The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the valuating clinician sees the resident, but how the resident performs on other shifts as well.  The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the last seven days irrespective of frequency.																		
				N=]	Nights	Γ	D=Day		E=Ever	nings									
		D	ay 1	Da	ay 2	D	ay 3	D	ay 4	Da	ıy 5	D	ay 6	A	3a				
Date			5/04		.6/04		17/04		18/04		9/04		0/04	9/21	1/04		Likely	_	ъ.
	trar		et Use – n/off to						`		-	,				Tr	ansmitte Value	d 	Review Value
			Int		Int		Int		Int		Int		Int		Int				
Self	N	F		F		F		F		F		F		F					
Perform *	D E	0		0		0		0		0		0		0					
Support	N D	E		E		E		E		E		E		E					
Provided	E	Y		Y		Y		Y		Y		Y		Y					
Resident Name PATTY PEAR Medical Record No. 908 ADL Score = Score =																			
Int. Signature Int. Signature Int. Signature Int. Signature																			
Rationale	: _																		
Example #9																			

9/21/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good, feeds self. No weight loss. Needs assisted with ADLs. Has a foley catheter and requires total assist daily with toileting and foley care. No new problems.

Self-Performance Key		Supp	ort Provide	d Key							
0 = IndependentNo help or oversight 1 = Supervision — Oversight, encouragement or cueing provided 2 = Limited Assistance — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 = Extensive Assistance—Resident performed part of activity but help of the following type(s) were p *Weight-bearing support *Full staff performance 4 = Total Dependence—Full staff performance of activity during entire shift 8 = Activity Did Not Occur on this shift	provided	1 =Setup he 2 =One pers 3 =Two+ pe 8 =Activity  The respons	son physical assist rsons physical assist did not occur ibility of the person co	ompleting the							
The responsibility of the person completing the documentation for self-performance is to capture the tot of the resident's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.		the maximu	ion for support provid m amount of support t er the last seven days i	the resident							
N=Nights D=Day E=Evenings	<b>.</b>		-								
Day 1 Day 2 Day 3 Day 4 Day 5  Date 9/15/04 9/16/04 9/17/04 9/18/04 9/19/04	Day 6 9/20/04	A3a 9/21/04									
Toilet Use - How resident uses the toilet room (commode, bedpan or uring transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusted.)	inal);	7/=4/01	Likely Transmitted Value	Review Value							
Int Int Int Int Int	Int	Int									
Self N F F F F F	F	F	]								
	$\mathbf{e}$	0	_								
E		L									
Support	E	E									
Provided	Y	Y									
Resident Name PATTY PEAR Medical Record No. 908			ADL Score =	ADL Score =							
Int. Signature Int. Signature Int.	Signature	I	nt. Sig	gnature							
Rationale:	Rationale:										

Example #9 \*See nurse's n

9/21/04 10:00 am. Weekly summary: Alert and oriented with periods of confusion. Skin intact. No mood or behavior problems. No restraints used. Appetite good, feeds self. No weight loss. Needs assisted with ADLs. Has a foley catheter and requires total assist daily with toileting and foley care. No new problems.

NOTE: While this note explains why the MDS is coded total assist for toilet use, it is not sufficient to support total assist for the case mix review.

Minimum Documentation Standards for Case Mix Review: Documentation requires 24 hours/7 days within the observation period while in the facility. Must have signatures and dates to authenticate the services provided.

				Sel	f-Per	forr	nance	e Ke	y					9	Supp	ort Provide	d Key
0 =Independ 1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b	on — C Assista ring of Assis earing	Oversight nce — Ref Iimbs tanceF Suppor	nt, encour esident h or other i Resident j	rageme ighly in non-we	nvolved i ight bear	n activ	vity; recei sistance			- 0		re prov	ided	1 = S 2 = O 3 = T	etup hel ne perso wo+ per	or physical help fror p only on physical assist sons physical assist id not occur	n staff
*Full staff 4 =Total Dep 8 =Activity I The responsit of the resider evaluating cl	pender Did No bility o ut's AL	nceFul ot Occur of the pe OL self-p	on this serson comperforman	shift ipleting ice over	the docu the seve	menta n day p	tion for se veriod, 24	elf-perf hours a	ormance 1 day – i.	e., not c	nly how		victure	docu the n recei	mentatio naximun	pility of the person co on for support provid a amount of support t the last seven days i	led is to code the resident
				N=	Nights	Γ	D=Day		E=Even	ings						_	_
		Da	ay 1	D	ay 2	D	ay 3	Da	ay 4	Da	ay 5	Da	ay 6	A	<b>13a</b>		
Date		9/1	5/04	9/1	16/04	9/:	17/04	9/1	8/04	9/1	9/04	9/2	0/04	9/2	21/04	Likely	
Bed Mobil	lity – 1	How re	sident m	noves t	o and fr	om lyi	ng positi	ion, tu	rns side	to side	e, and po	ositions	s body v	vhile ir	n bed.	Transmitted Value	Review Value
			Int		Int		Int		Int		Int		Int		Int		
	N	2	FS	2	FS	2	FS	2	FS	2	RS	2	RS	2	RS		
Self Perform	D	2	ES	2	ES	2	ES	2	ES	2	RS	2	RS	2	ES		
1 CHOIH	Е	2	TS	2	TS	2	TS	2	TS	2	FS	2	ES	2	TS		
	N	2		2		2		2		2		2		2			
Support	D	2		2		2		2		2		2		2			
Provided	Е	2		2		2		2		2		2		2			
Resident N	ADI ADI																

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
FS	Fred Skeleton, CNA	ES	Ed Skeleton, CNA	TS	Ted Skeleton, CNA	RS	Red Skeleton, CNA

Rationale:

9/22/04 2:00 pm. Quarterly care plan note: ADL grid is incorrect. Following staff interviews and observation, it has been determined that Mr. Way requires extensive assist of one for bed mobility, transfers, toilet use and eating. He is alert but confused and disoriented.

					Sel	f-Per	fori	nanc	e Ke	e <b>y</b>					9	Supp	or	t Provid	ed I	Key
0 =Indepo 1 =Superv 2 =Limite manev 3 =Extens *Weigh *Full st	vision of Assiuvering Sive Assit-bear	—Ovistang of ssista	versigh ice – Re limbs anceR suppor	t, encour esident h or other i desident	agemen ighly in non-we	volved ight bea	in activ	vity; recei sistance	•	•			re prov	ided	1 =S 2 =C 3 =T	etup hel Ine perso wo+ per	p on on pl	hysical help fr ly hysical assist physical assis ot occur		ff
4 =Total I 8 =Activit The respo of the resi evaluating	Depend ty Did Insibili Ident's	dend Not ty of AD	ceFull Occur f the pe L self-p	on this s erson com performan	shift ipleting ice over	the doci	umenta en day j	tion for s period, 24	elf-perf hours	<sup>c</sup> ormance a day - i.	.e., not d	nly how	e total p	oicture	docu the n recei	mentation naximun	on fo n am	y of the person or support prov ount of suppor last seven day	ided is t the r	s to code esident
					N=	Nights	Ι	D=Day		E=Ever	nings				•			rror -,		
			Da	ay 1	D	ay 2	Г	Day 3	D	ay 4	Da	ıy 5	D	ay 6	A	13a	Se	error—, se nurse's ote 9/22/04 Likely		
Date			9/1	5/04	9/1	6/04	9/	17/04	9/1	18/04	9/1	9/04	9/2	20/04	9/2	21/04	N	te <sup>9/22</sup> / Likely		
Bed Mo	bility	- H	Iow re	sident m	noves t	o and fr	om ly	ing posit	tion, tu	rns side	to side	, and po	osition	s body v	while ii	n bed.		Transmitted Value		Review Value
				Int		Int		Int		Int		Int		Int		Int				
Self	N	1	2	FS	2	FS	2	FS	2	FS	2	RS	2	RS	2	RS				
Perform	n L	)	2	ES	2	ES	2	ES	2	E8	2	RS	2	RS	2	ES				
	1	Е	2	TS	2	TS	2	TS	2	TS	2	FS	2	ES	2	TS			_	
Support		N	2		2		2		2		2		2		2					
Provide	- 1 1	)	2		2		2		2		2		2		2					
		Е	2		2		2		2		2		2		2					
Resident	nt Name WRONG WAY Medical Record No. 1001 ADL Score = Score =																			
Int.	nt. Signature Int. Signature Int. Signature Int. Signature																			
S F	red Sk	ęlet	on, CN	(A	ES	Ed.	Skęlet	on, CNA			TS	Ted S	keleton	ı, CNA		R	s	Red Skeletor	r, CN	<u> </u>
Ration	ale:																			
xample:	#10																			

						_	
	Self-Pe	rforman	ce Key			Suj	pport Provided Key
0 =Independent-No help or over 1 =Supervision - Oversight, enco 2 =Limited Assistance - Resident maneuvering of limbs or othe 3 =Extensive AssistanceResident *Weight-bearing support *Full staff performance 4 =Total DependenceFull staff p 8 =Activity Did Not Occur on this  The responsibility of the person co of the resident's ADL self-perform clinician sees the resident, but how	uragement or cu highly involved r non-weight be t performed par performance of a s shift empleting the doc ance over the sec	1 =Setup h 2 =One pe 3 =Two+ p 8 =Activity	nelp or physical help from staff nelp only reson physical assist persons physical assist y did not occur  assibility of the person completing the attion for support provided is to code the amount of support the resident received set seven days irrespective of frequency.				
	N=N:	ights D=	Day E	=Evenings			
Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a	

			,		J		· <i>J</i> ·				<i>J</i> -		<i>J</i> -		
Date		9/1	5/04	9/1	16/04	9/:	17/04	9/1	.8/04	9/1	9/04	9/2	0/04	9/2	21/04
Bed Mobil	l <b>ity -</b> ]	How re	sident m	noves t	o and fr	om lyi	ng posit	ion, tu	rns side	to side	e, and po	ositions	s body v	vhile ir	n bed.
			Int		Int		Int		Int		Int		Int		Int
Self	N	4	BB	4	BB	4	ВВ	4	NB	4	NB	4	NB	4	BB
Perform	D	4	LB	4	LB	4	TS	4	TS	4	TS	4	LB	4	LB
Support	N	2		2		2		2		2		2		2	
Provided	D	2		2		2		2		2		2		2	

Likely Transmitted Value	Review Value

Resident Name STRING BEAN Medical Record No. 1101 ADL Score = Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
ВВ	Betty Bones, RN	LB	Letty Bones, LPN	NB	Nettie Bones, CNA	TS	Ted Skeleton

Example # 11 Rationale: \_\_\_\_\_

		Self-Pe	Su	pport Provided Key								
1 =Supervisi 2 =Limited A maneuve 3 =Extensive *Weight-b *Full staff 4 =Total Dep	entNo help or overs on – Oversight, encou assistance – Resident ring of limbs or other AssistanceResident earing support performance bendenceFull staff p Old Not Occur on this	1 =Setup h 2 =One pe 3 =Two+ p 8 =Activity	up or physical help from staff nelp only rson physical assist persons physical assist y did not occur									
of the resider	bility of the person con it's ADL self-performa is the resident, but how	ince over the sev	en day period, 2	4 hours a day –			documenta maximum	ation for support provided is to code the amount of support the resident received est seven days irrespective of frequency.				
	N=Nights D=Day E=Evenings											
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	A3a					
Date	9/15/04	9/16/04	9/20/04	9/21/04	Likely							

Date		9/1	5/04	9/1	16/04	9/1	17/04	9/1	8/04	9/1	9/04	9/2	0/04	9/2	1/04
Bed Mobi	lity – l	How re	sident m	oves t	o and fr	om lyi	ng positi	ion, tu	rns side	to side	e, and po	ositions	s body v	vhile ir	n bed.
			Int		Int		Int		Int		Int		Int		Int
Self	6A	0	LB	4	BB	0	BB	0	BB	0	LB	0	LB	0	LB
Perform	6P	0	NB	0	NB	0	NB	3	TS	0	TS	0	TS	0	NB
Support	6A	0		0		0		0		0		0		0	
Provided	6P	0		2		0		2		0		0		0	

Likely Transmitted Value	Review Value

Resident Name GREEN BEAN Medical Record No. 1201 ADL Score = Score =

Int.	Signature	Int.	Signature	Int.	Signature	Int.	Signature
ВВ	Betty Bones, RN	TS	Ted Skeleton	LB	Letty Bones, LPN	NB	Nettie Bones, CNA

Example # 12 Rationale: \_\_\_\_\_

# Case Mix Review

#### State of Louisiana

#### Department of Health and Hospitals Medicaid Case Mix Review Verification Process Project Overview

#### **Case Mix Review Program Timeline**

- □ Timeline for case mix verification process
  - o 01/01/2005 to 06/30/2005
  - o 07/01/2005 to 06/30/2006
  - o 07/01/2006 to 06/30/2007

#### **Policy Decisions for Case Mix Verification Reviews**

- Delinquent MDS Assessment Definition
  - Any assessment with an R2b date greater than 121 days from the previous R2b date will be deemed delinquent and assigned a RUG-III code of BC1
- □ Case Mix Supportive Documentation Guidelines
  - o Guidelines that define the supporting documentation necessary at the case mix review to verify a RUG-III MDS item
- Unsupported MDS Assessment Definition
  - When the case mix verification review results in a new RUG-III classification
- □ Frequency of Case Mix Reviews
  - Currently 50% of all Medicaid certified facilities are selected for review annually
- □ Sample Payer Source Selection
  - All payer types
- □ Primary Sample Size

The greater of:

- o 20% of the residents listed on the final CMI report
- o 10 assessments
- □ Expanded Sample Size (required if primary sample is greater than 25% unsupported)

The greater of:

- o 20% of the residents listed on the final CMI report
- o 10 assessments
- Required ADL documentation to reflect the observation period 24/7
  - o ADL grid
  - ADL narrative
  - Any combination
- ☐ Threshold Defines When Corrective Action is Applied
  - o Greater than 40% unsupported (01/01/2005 to 06/30/2005)
  - o Greater than 35% unsupported (07/01/2005 to 06/30/2006)
  - o Greater than 25% unsupported (07/01/2006 and beyond)

- □ Phase In Corrective Action
  - o ReRUG all unsupported assessments when the facility exceeds the State threshold beginning 01/01/2005
- □ Follow-up Review Process
  - The Department reserves the right to conduct a follow-up review as needed but not earlier than 120 days following the exit date of the prior case mix review
  - The Case Mix Documentation Improvement Plan (DIP) may be required by DHH after the follow-up review and submitted to DHH on the designated due date
  - The DIP will serve to guide the next review process at the facility and determine if corrections have been implemented

#### **On-site Review Protocol**

- □ Facility Notification will occur no less than two (2) business days prior to the expected on-site review
  - o First by phone
  - Second by fax
- □ Entrance conference provided prior to the beginning of the case mix review
  - Recommend facility Administrator, MDS coordinator and any other staff of facility choice
  - o Reviewers will explain process and identify facility liaison
  - o Reviewers will identify chart order and specific documentation needs
- Review process
  - Facility liaison will be provided a list of resident chart documentation needed
  - o Reviewers will only request a portion of total documentation needs to minimize chart removal from the resident chart location
  - o Reviewers will request the liaison to supply any documentation they are unable to locate in the medical chart
  - Facilities are NOT requested nor required to collate supporting documentation for the RN reviewers
- □ Exit conference provided following the completion of the case mix review
  - o Exit conference is an educational, learning experience
  - Facility Administrator or designee may invite any staff deemed appropriate to attend the exit conference
  - Reviewers will report the findings including the number of assessments reviewed sorted by RUG-III category and % unsupported
  - No supporting documentation may be submitted after the close of the exit conference

#### **Post Review Protocol**

- □ Facility will receive a post review letter no later than 10 business days following the exit conference date
- □ For facilities that exceed the State threshold, a Post CMI Review roster will be sent with post review letter

- □ Facility has 15 business days from receipt of the post review letter to request an informal reconsideration
- □ DHH response to the informal reconsideration no later than 10 business days following the receipt of the request for an informal reconsideration
- □ Facility has 30 business days following receipt of decision from DHH regarding the request for informal reconsideration to appeal findings
- □ No appeal will be considered unless the facility has exercised the informal reconsideration process

## State of Louisiana Department of Health and Hospitals Post Review Timeline Sample

Requirement	Timing	Example
Exit Conference	Any date	03/01/2005
10-Day Summary	Must be submitted to the facility no later than 10	03/15/2005
Letter	business days following the exit conference	
Informal	A formal request to DHH no later than 15	04/05/2005
Reconsideration	business days following receipt of the 10-day	
	summary letter	
DHH Response to	A decision from DHH regarding the facility's	04/19/2005
the Informal	request for reconsideration of a review matter no	
Reconsideration	later than 10 business days following the receipt	
	of the request for an informal reconsideration	
Appeal Process	No later than 30 business days following receipt	05/31/2005
	of the decision from DHH regarding the request	
	for the informal reconsideration	
	Note: No appeal will be considered unless the	
	facility has exercised the informal	
	reconsideration process	
Repeat Review	No sooner than 120 calendar days following the	06/29/2005
	exit conference date	

# State of Louisiana Department of Health and Hospitals Medicaid Case Mix Review and Rate Timeline

MDS Review Period	MDS assessments complete with an R2b date on or before the point in time date provided on the CMI Report	Rate for Quarter
January February March	(CMI Report dated 10-01-year) July, August, September Assessments	January February March
April May June	(CMI Report dated 01-01-year) October, November, December Assessments	April May June
July August September	(CMI Report dated 04-01-year) January, February, March Assessments	July August September
October November December	(CMI Report dated 07-01-year) April, May, June Assessments	October November December

Prepared by Myers and Stauffer LC 2005

# State of Louisiana Department of Health and Hospitals Medicaid Case Mix Documentation Improvement Plan (DIP) Procedure

The Case Mix Documentation Improvement Plan (DIP) may be required by DHH after the follow-up facility Medicaid Case Mix medical record review and submitted to DHH on the designated due date. The purpose of the DIP is to establish an expected implementation timeline for corrective action and ensure future compliance with the documentation guidelines.

The DIP is required to be completed and submitted to DHH no later than 15 business days from receipt of the case mix review findings letter. The DIP will identify areas of concern noted during the previous review. The facility is responsible for submitting a plan for compliance and providing an implementation date for the plan.

The DIP will serve to guide the next review process at the facility and determine if corrections have been implemented.

## State of Louisiana Department of Health and Hospitals Medicaid Case Mix Documentation Improvement Plan (DIP)

## Facility Name Facility Address

Date of l	Exit Conference	<u></u>	% Unsupported	
DIP Res	ponse Due Date			
Date	Areas of Concern	Documentation Improvement Plan	Implementation Date	Signature
Admin	istrator's Signature		Date	

## Resources

## State of Louisiana Department of Health and Hospitals A Quick List of Louisiana Help Desks

Several different parties assist the assessment transmission and validation process. Myers and Stauffer LC is responsible for the Medicaid Rate Setting Process, associated assessment data and any report that bears the name of Louisiana Department of Health and Hospitals, Rate and Audit Review. We have detailed the major breakdown of each party's responsibilities below, however, you may call us initially if you are unsure of whom to contact and we will assist you in finding an answer to your question or direct you to the appropriate desk.

#### Medicaid Case Mix RN Reviewer

Questions concerning Medicaid Case Mix Reviews Ruby Pecot (225) 342-6158

### Myers and Stauffer LC (800) 763-2278 or (317) 816-4124

All questions related to Medicaid RUG-III classification calculations, preliminary or final resident listings report or Medicaid Case Mix Review.

Myers and Stauffer LC (800) 374-6858 or (816) 968-1977

All questions related to the provider rate.

### Louisiana MDS Help Line (800) 261-1318

Questions related to the definition, completion or interpretation of the MDS 2.0 Resident Assessment Instrument. This line provided by Department of Health and Hospitals, Health Standards Section. Evelyn Enclarde, RN, State RAI/MDS Coordinator responds to these calls.

### Medicare Date Communication Network (MDCN) Helpdesk (800) 905-2069

- \* Connection problems to MDCN (Medicare data Communication Network)
- \* MDCN ID's and passwords

Unisys - Provider Relations (800) 473-2783 or (225) 924-5040

Unisys - Provider Enrollment (225) 923-8510

**Unisys - Long Term Care Unit - (225) 237-3259** 

## REVS (800) 776-6323 or Telephonic Automated (225) 216-7387

Recipient Eligibility Verification System

### **DHH Regional Office (800) 834-3333**

Providers contact for eligibility issues. Providers may also contact the appropriate DHH Parish Office for eligibility issues.

### Raven Help Desk (800) 339-9313

Questions about the RAVEN software

## MDS WEB ADDRESSES TO EXPLORE FOR INFORMATION AND RESOURCES

CMS MDS 2.0 Information- MDS Q&A

http://cms.hhs.gov/medicaid/mds20/default.asp http://cms.hhs.gov/medicaid/mds20/whatsnew.asp

**Correction Policy** 

http://www.cms.hhs.gov/medicaid/mds20/rai1202ch5.pdf
This is Chapter 5 in the new RAI Manual 2002

Federal Register- Listing of all the proposed federal laws http://www.gpo.access.gov/fr/

Louisiana Department of Health and Hospitals Evelyn Enclarde, RN, RAI Coordinator (Health Standards) <a href="http://www.dhh.louisiana.gov/offices/?ID=112">http://www.dhh.louisiana.gov/offices/?ID=112</a>

Louisiana Department of Health and Hospitals Ruby Pecot, RN, Medicaid Case Mix RN Reviewer (Rate and Audit) http://www.dhh.louisiana.gov/rar

MDCN software (AT&T Global) – <a href="http://www.attbusiness.net/softctr/software.html">http://www.attbusiness.net/softctr/software.html</a> <a href="http://www.cms.hhs.gov/mdcn/default.asp">http://www.cms.hhs.gov/mdcn/default.asp</a>

MDS RAI Manual 2002 and Updates <a href="http://www.cms.hhs.gov/medicaid/mds20/man-form.asp">http://www.cms.hhs.gov/medicaid/mds20/man-form.asp</a>

MDS Software and forms on the CMS site http://cms.hhs.gov/medicaid/mds20/man-form.asp

Medicare Information- Information the public can use to evaluate a nursing facility <a href="http://www.medicare.gov/nhcompare/home.asp">http://www.medicare.gov/nhcompare/home.asp</a>

Privacy Act information <a href="http://aspe.os.dhhs.gov/admnsimp/">http://aspe.os.dhhs.gov/admnsimp/</a>

RAVEN software- Allows entry of MDS information and creation of files for submission to CMS

http://cms.hhs.gov/medicaid/mds20/raven.asp

## Department of Health and Hospitals



**Current Information on Louisiana Case Mix Reimbursemen** 

Vol. 4, Issue 1 - March 2005

### The Louisiana Advisor is a publication produced under contract with The **Department of Health** and Hospitals by Myers and Stauffer LC 9265 Counselors Row, Ste. 200 Indianapolis, IN 46240

The Louisiana Advisor is published to keep all interested parties current on Louisiana Case Mix Reimbursement. Its goal is to provide information on major issues, work groups, and upcoming activities. The articles presented here are only a synopsis of the topics and are not intended to present a complete analysis of the issues.



**Documentation** or Review Ouestions? Medicaid Case Mix RN Manager (225) 342-6158

**MDS Clinical Ouestions?** Health Standards (800) 261-1318

**Medicaid CMI** Report Questions? Myers and Stauffer (800) 763-2278

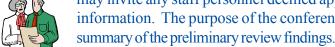
## 2005 Case Mix Review Process

The corrective action phase of the Medicaid Case Mix Documentation reviews began January 31, 2005. Approximately 50% of the facilities in the state will be selected and reviewed.

**Pre-Review Procedure:** Upon arrival at the facility, the review team will introduce themselves and present an introduction letter that will list the reviewer(s) by name. The lead RN reviewer will explain the purpose of the visit and invite the Administrator, DON, MDS coordinator and facility liaison to meet for a short Entrance Conference

During the Entrance Conference, the lead RN reviewer will describe the Medicaid Case Mix documentation verification process, identify a facility liaison, describe the necessary documentation required and request the first set of resident medical records to be reviewed. After answering facility questions, the Medicaid Case Mix documentation verification process will begin.

**Post-Review Procedure:** Once the legal medical record documentation review is complete, the facility staff shall be invited to participate in an Exit Conference. The facility Administrator may invite any staff personnel deemed appropriate for the Exit Conference information. The purpose of the conference is to provide the facility with a



The lead RN will provide the facility with the number of assessments reviewed, including the

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total for each RUG-III category, explain the percent "Unsupported", provide individual assessment comments and notable trends observed in the facility and answer all questions possible. Signatures will be obtained from all participants and the lead RN will provide the facility with a copy of the Exit Conference form if desired.

The Exit Conference form will serve as a record of the preliminary review

(continued on page 2)

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## 2005 Case Mix Review Process continued...

findings as well as topical educational issues discussed. At a minimum, this educational opportunity will address the areas in which the facility needs assistance with case mix documentation and review requirements. The Exit Conference will serve as the final opportunity for the staff to provide any further documentation to fully disclose the extent of services provided to the residents. Any documentation produced after the close of the Exit Conference will not be considered as supporting documentation per Rule LAC 50:VII.1313 (B2).



Within 10 business days following the exit conference date, the facility will receive a summary letter describing the results of the facility review statistics and any noted trends

or documentation issues. If the review results in an unsupported percent greater than 40%, the unsupported assessments will be re-RUGged and a Post CMI Report will be sent with the summary letter. The unsupported records will be designated with an "R" in the note column of the Post CMI Report.

*Informal Reconsideration:* Upon receipt of the 10 business day summary letter, should the facility wish to exercise an informal reconsideration, a request from the facility to DHH must be received by DHH within 15 business days. The letter from the facility must describe, in detail, the facility's disagreement with the review findings. DHH will review the facility's informal dispute and must respond to the facility, by letter, within 10 business days.

**Appeal Process:** Should the facility continue to disagree, the facility has the right to request a formal appeal within 30 business days of receipt of the State's decision regarding the informal reconsideration.

**Reminder:** Per the MDS Verification Rule, any facility wishing to request an appeal must first exercise the informal reconsideration process. Should the facility not request an informal reconsideration, the formal appeal will be denied by the State.

## Dear Cindy...

The "Dear Cindy..." column is a regular feature in each issue of *Louisiana Advisor*. Cindy Smith, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues.

## Dear Cindy:

- Q. Do I need to modify records found to be unsupported at the Medicaid Case Mix review?
- A. Only records with inaccurate information that meet the definition for significant correction or modification should be modified. Remember, an unsupported record means that the documentation found at the review resulted in a RUG-III classification change; it does not mean that the MDS was inaccurate.

For instructions on correcting errors in an MDS record that has been accepted into the state MDS database, refer to the RAI Manual, Pages 5-7 through 5-19.

Please submit your questions to the Myers and Stauffer Help Desk Staff 800-763-2278.

## 2004 Review Results

Medicaid Case Mix Documentation reviews for 2004 started on January 19th, 2004, and were completed on June 25th, 2004. Approximately 50% of the facilities in the state were reviewed. The facilities selected for review in 2004 had 20% of the residents reviewed as the primary MDS random assessment selection. An expanded review was required if the primary sample review resulted in greater than 25% unsupported. The expanded review included another 20% sample.

The state average unsupported percent for the 2004 reviews was 44%. This is an improvement over the previous year's average unsupported percent of 70%. The impaired cognition MDS items (B2a, B4, and C4) had the highest unsupported rate at 83.8%, followed by ADLs (G1aA, G1bA, G1hA, and G1iA) at 74.6%.

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## 2005 Corrective Action Begins

The Medicaid Case Mix Reviews beginning 2005 may result in a corrective action to the facility. The following are the steps of the corrective action process:

- Step 1 Primary sample of 20% or 10 assessments (whichever is greater) is reviewed. Should the percent unsupported be greater than 25%, an expanded review will occur. However, should the percent unsupported be 25% or less, the review ends and NO corrective action is applied.
- Step 2 If the review is expanded, an expanded sample of 20% or 10 assessments (whichever is greater) is reviewed. Should the total percent unsupported be greater than the State threshold of 40%, all unsupported assessments will be re-Rugged. A new Post CMI Report will be processed that includes the new RUG-III codes for those unsupported assessments. A retro rate adjustment may be applied to the following quarter's rate.

Should the expanded review result in 40% or less unsupported, no unsupported assessments will be re-Rugged and **NO** corrective action applied.

## Medical Record Documentation





"I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

Should the facility identify differences between what is documented and what is fact, the appropriate professional must make a legal

medical notation in the medical record. MDS coding must, in all cases, reflect accuracy of the resident's facts. When facility documentation is inaccurate, the facility should take appropriate action to educate staff. In no case

should a facility code the MDS to reflect inaccurate medical documentation.

#### LOUISIANA TIMELINE

### **MARCH**

• Final CMI Report for 1/1/05

## 0

2

• Preliminary CMI Report for 4/1/05

• Training

#### JUNE

• Final CMI Report for 4/1/05

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## Training, Training, Training



Training topics will include the following:

- New, updated Supportive Documentation Guidelines
- Emphasis on CMI Report understanding
- Rate adjustment procedure

Stay tuned for more details!!

LA Department of Health & Hospitals BHSF Rate & Audit Review P.O. Box 546 Baton Rouge, LA 70821-0546

ROUTE TO:	
Administrator	
Director of Nursing	
MDS Coordinator	
Data Entry Personnel	
Consultants	
Other	
o their	

ATTENTION:
MDS
COORDINATOR